

Nishnawbe Aski Nation

# Health Directors Meeting on Health Transformation

January 29 & 30, 2018 – Thunder Bay

MEETING SUMMARY REPORT (May 1, 2018)

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## EXECUTIVE SUMMARY

The following report is a summary of the Nishnawbe Aski Nation (NAN) Health Directors Meeting on Health Transformation that took place in Thunder Bay, Ontario, on January 29 & 30, 2018. This meeting was coordinated by NAN with the purpose of:

- Updating the health directors on the work of the health transformation process
- Gathering feedback on:
  - Identification and prioritization of immediate issues;
  - The meaning of transformation and how to move forward; and
  - How engagement and communication should occur.

The meeting was chaired by Wally McKay and was attended by Community Health Directors, Tribal Council Health representatives, Health Authority representatives, Health Transformation Support Team representatives, Chiefs Councils on Health Transformation representatives, NAN Staff, Elders and observers.

In giving an overview of the process the following key messages were provided:

- Self-Determination and recognition of First Nations rights means that decision making on all levels should involve our people. This will involve going beyond our existing institutions and developing our own laws.
- The *Charter of Relationship Principle Governing Health System Transformation in NAN Territory* represents a historic commitment on the part of both levels of government that has never been seen before.
- Transformation is about bringing resource allocation, accountability and responsibility back to the communities – not to take away from work being done by First Nations, Tribal Councils and Health Authorities.
- A framework to deal with immediate issues is being developed.
- Transformation must occur from the ground up - NAN is dedicated to finding the best way to involve health directors and other front-line workers.
- There is no blueprint for moving forward; however, what is certain is that the key to moving forward is engagement – to hear peoples' stories, to be listening, hearing empathizing and believing.
  - We are looking to the health directors to help design that process and determine what should be done at the community level.

## Immediate Issues

Small group discussions were held as participants were organized into six groups of 8-10 people. On the first day groups identified the immediate issue that should be addressed through the process and identified their top priorities among the list of immediate issues. Priorities can be summarized into the following themes (in no particular order):

- Mental Health & Addictions
- Access to specialist and allied health professionals
- Access to physicians and nurses
- Diabetes
- Elder Care
- Maternal Health, Early Years, Child Development
- Screening, prevention, early identification and public health
- Case management and client coordination/supports
- Emergency Response
- Food Security
- Infrastructure
- Data & Electronic Medical Records (EMR)
- Water, Housing & Poverty
- Health Human Resources and Capacity Building
- Non-Insured Health Benefits (NIHB) program
- Legislation, Policy and Funding
- Wholistic approach with culture and language as foundation
- Governance and structure of health system (community structure & regional structure)

## Prioritization of Immediate Issues

Groups were asked to prioritize their identified immediate issues. Each group took their own approach to prioritization and a survey was distributed. Although NAN made it clear that there will be additional mechanisms for prioritization. The results from the meeting will be very useful in moving forward. There was general consistency around the following five priorities:

- Mental Health and Addictions (youth and family treatment and aftercare)
- Infrastructure (water, housing, space to provide services)
- Elder care and long-term care
- Addressing NIHB issues
- Funding mechanisms

## What does Health Transformation Mean?

Participants were asked “What does Health Transformation Mean to You?” Responses were synthesized into the following themes:

- Healthy Communities and Ownership over Health
- First Nations Self-Determination and Jurisdiction

- Treaty Right to Health and Federal Fiduciary Responsibility
- Community Control
- Capacity Building and Health Human Resource Development
- Equitable Access to Services & New Models of Care
- Wholistic Models of Care & Restoring Community Wellness
- Communication and Coordination

### **Implementation of Health Transformation**

With regards to implementation of health transformation, participants provided comments touching upon the following themes:

- Knowledge Translation & Best Practices
- New Models of Care and Increased Access
- Wholistic and Land-Based Models
- Address Funding and Reporting Barriers
- Coordination and Partnership
- Communicating the Transformation Process
- Foster Change at the individual and community level
- Advocacy and Supports for Patients
- Governance and Jurisdiction
- Build Capacity
- Support existing First Nations models

### **Engagement and Communication**

Groups reported on how they would like to be engaged and how communication should take place. There was consensus that community engagement must be an ongoing process with multiple opportunities to participate and community visits. Extensive feedback was provided on engagement methods, approaches, considerations and the people that should be involved. The overarching message was that as many people as possible should be engaged and communities should have ongoing involvement, including pre-planning and education on the process.

### **Effective use of Existing Resources**

Participants provided recommendations on how to effectively use existing resources.

Discussions touched on the following themes:

- Improve retention and recruitment
- Remove barriers to using resources
- Partnerships and alignment of resources
- Traditional and Wholistic approaches

## Next Steps and Moving Forward with Transformation

A discussion about moving forward took place highlighting the key messages:

- The process should be implemented right away – the sooner the better.
- An engagement approach and process will be determined in the next couple of weeks including the resource allocation to support the process.
- A communication plan will be implemented to keep everyone informed.
- Grand Chief Alvin Fiddler has made a personal commitment as this portfolio falls directly under him. Grand Chief Alvin Fiddler commands the respect of the government as evidenced by their commitment to the process and in the Prime Minister Justin Trudeau visiting NAN territory and Ontario Premier Kathleen Wynne attending the NAN Chiefs Winter Assembly.
- We want you to keep us accountable and keep our feet to the fire.

## INTRODUCTION

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- Updating the health directors on the work of the health transformation process
- Gathering feedback on:
  - Identification and prioritization of immediate issues;
  - The meaning of transformation and how to move forward; and
  - How engagement and communication should occur.

The meeting was chaired by Wally McKay and was attended by Community Health Directors, Tribal Council Health representatives, Health Authority representatives, Health Transformation Support Team representatives, Chiefs Councils on Health Transformation representatives, NAN Staff, Elders and observers.

<b>AGENDA</b>
<b>Health Directors Meeting on Health Transformation – January 29-30, 2018</b>
<b>DAY 1 – January 29</b>
<ul style="list-style-type: none"> <li>➤ Opening Song</li> <li>➤ Opening Prayer</li> <li>➤ Welcoming Remarks – Deputy Grand Chief Fox</li> </ul>
<ul style="list-style-type: none"> <li>➤ Why are we here? Elsie and Donald Brown, Wapekeka First Nation</li> </ul>
<ul style="list-style-type: none"> <li>➤ How did we get here?           <ul style="list-style-type: none"> <li>○ Overview of Health Directors Meeting on Health Transformation</li> <li>○ Introduction of Health Transformation Support Team</li> <li>○ Ovide Mercredi, Health Transformation Lead Negotiator</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>➤ Health Transformation Support Team Update – Sol Mamakwa</li> </ul>
<ul style="list-style-type: none"> <li>➤ Small Group Discussion – What are the immediate issues?</li> </ul>
<ul style="list-style-type: none"> <li>➤ Small Group Discussion – How do we prioritize and address the immediate issues?</li> </ul>
<ul style="list-style-type: none"> <li>➤ Group Reports</li> </ul>
<b>DAY 2 – January 30</b>
<ul style="list-style-type: none"> <li>➤ Welcoming Remarks, Recap of Day One and Overview of Day Two– Wally McKay</li> </ul>
<ul style="list-style-type: none"> <li>➤ Small Group Discussions:           <ul style="list-style-type: none"> <li>○ What does Health Transformation mean to you?</li> <li>○ How do we implement Health Transformation?</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>➤ Large Group Discussion on Health Transformation</li> </ul>
<ul style="list-style-type: none"> <li>➤ Small Group Discussions:           <ul style="list-style-type: none"> <li>○ How do you see engagement and communications happening in and with your communities?</li> </ul> </li> </ul>

○ How do we prepare our community members for Health Transformation?
○ Small Group Discussion – How do we effectively use existing resources?
○ Group Reports
○ Next steps
○ Closing Ceremony
○ Closing Song
○ Closing Prayer

**Welcoming Remarks**

Following the opening song and opening prayer, welcoming remarks were made by Deputy Grand Chief Derek Fox. He set the context of the meeting, outlining the overarching goal of why we are here, stating: ‘We are here for our people.’ He described the challenges and the losses that NAN territory has experienced. He described the grief that is felt across the territory from losing 38 people because of suicide last year. By traveling to the communities, it educates us on what front-line workers go through every day.

He explained the objective of the meeting as being for participants to get an understanding of what Health Transformation means, but also noted that it is a process, and this is the first of many meetings. The process will be based on community voices and experiences – it is their voices that will put it into motion.

**Why are we here? Elsie & Donald Brown**

Elsie and Donald Brown, Wapekeka First Nation, provided their experience with the health care system and the challenges they face. Four years ago, Donald was paralyzed from a stroke. It impacted his mobility, speech, eye-sight and his memory. Doctors estimated that he would be back to normal within two years, but it is now four years later, and his condition has not significantly improved. Elsie described the challenges of not having home care, physiotherapy or respite supports in the community and having to make sure that he is not left alone. Non-Insure Health Benefits (NIHB) has denied requests for him to have an escort despite not being able to see or speak properly.

Elsie also spoke of the recent experience of losing her 13-year-old grand-daughter to suicide. She described the day of the incident and the impact and deep grief experienced by the family and how she continues to cry and mourn. She also spoke about losing her 16-year-old son to suicide in 1997.

Dr. Mike Kirlew commented on the story, describing it as “a story of courage, perseverance and hope” and how stories like these are seen all over NAN territory as access to services are lacking and they do not receive the services that other people get (physiotherapy, Occupational Therapy, speech pathology, etc.). Otherwise if a service is available, one must travel hundreds of kilometers to access it.

Dr. Kirlew described the power of these stories and truth telling opportunities in guiding transformation “Those who speak will speak the truth and those who hear will hear the truth – the truth is going to drive transformation.”

### **How did we get here? Ovide Mercredi**

Ovide Mercredi, Health Transformation Lead & Negotiator, gave an overview of the process which included the following key points:

- Decisions need to involve our people. Decisions should not be made in Ottawa, Thunder Bay or Sioux Lookout. It also means recognizing the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) including the right to health self-determination.
- We are also creating a framework to include a process to address the immediate needs identified by NAN communities and health authorities.
- The province has made a commitment to fund capital expenditures on reserve. We need a project and we need to test this commitment. Right now, I believe them. We need to believe to move forward.
- Charter of Relationship Principles and commitments:
  - There is a commitment to policy reform. We know that Contribution Agreements are not working for you and your people.
  - It is a major announcement and commitment that the governments are committed to legislative change. We have never had an opportunity like this in a life time.
  - They are also committed to developing a new fiscal arrangement. Ultimately the primary accountability will be to our people.
  - There is a commitment to multi-sectoral solutions that will allow us to work together and break down the silos that the system has created in our communities.
  - They have committed to breaking down barriers. You know what the barriers are. We need to go at them one by one – but it is not enough to just change the barriers, we need to reform the system. This will include a new system of medical transportation, new models of care and creating economic opportunities.
- Ovide also summarised the key points from the Health Summit and the demands made to the Ministers who were present (Minister Jane Philpott and Minister Eric Hoskins):
  - We require a binding commitment to address jurisdiction and recognise our inherent right to jurisdiction over health.
  - The process must be integrated and wholistic to include health and social.
  - The process must recognise the diversity of our communities.
  - Urgent and immediate needs must be addressed right away.

- We need a funding commitment that will allow our communities to take a lead role in the process.
  - We need a commitment to build the capacity. We want our own doctors and institutions.
  - Treaty Rights and reconciliation must be the foundation of the process.
  - The system must include spirituality and choice between traditional and Christian ways so that people can use every which way to heal themselves.
  - Governments must appoint lead negotiators who are Indigenous and have authority.
  - We must be able to benefit from economic spin-offs and the profits made in different areas such as pharmacy and emergency transportation (e.g. Ornge).
- We are very dedicated to finding the best ways to involve you. We need your help. Without you we cannot do this. Transformation must be from the ground up. It starts with us individually as we will make change individually. We can liberate ourselves from the impact of colonization on our people. We can liberate ourselves – it is an individual choice.

### **Health Transformation Support Team Update – Sol Mamakwa**

Sol Mamakwa, NAN Internal Health Transformation Lead, built upon Ovide's comments and provided a more technical overview of the process. He presented a Power Point Presentation with the following themes:

- History: How did we get here?
- What is Health Transformation?
- Why Health Transformation?
- Advocacy Health Transformation
- Updates on Health Transformation
- Community Engagement

He also added the following key messages:

- There is no blueprint – it is up to us to determine what to do and it is important that it is at the community level and we are here today for you to help us determine what should be done at the community level.
- We need to bring resource allocation, accountability and responsibility back to the communities. Health transformation is to give back to the community – but not to take away from the good work happening at the Health Authorities, Tribal Councils and communities.
- Today is the marker of that change – today is the beginning of a journey to begin to talk about the best way to engage communities.

- It is for us to decide what equity is – governments cannot decide for us and if done right, we can have a better system than Ontario or Canada, we just have to do it right.
- He outlined the teams that have been organized to guide the process:
  - **Health Transformation Support Team:** Pat Chilton, Mae Katt, Dr. Doris Mitchell, Dr. Mike Kirlew, Ennis Fiddler, Helen Cromarty (Elder) and Natasha Sugarhead (Youth).
  - **Chiefs Council on Health Transformation** will provide political leadership and includes:
    - Chief Ignace Gull, Attawapiskat First Nation
    - Chief Clifford Bull, Lac Seul First Nation
    - Chief Andrew Solomon, Fort Albany First Nation
    - Chief Ellen Vontane-Keno, McDowell Lake First Nation
    - Chief Alex Batisse, Matachewan First Nation
    - Chief Titus Tait, Sachigo Lake First Nation
  - **NAN Internal Team** will fall under Grand Chief Alvin Fiddler’s portfolio and includes the following: Ovide Mercredi, Sol Mamakwa, Paula Vangel, Wendy McKay and John Cutfeet.
- The key in moving forward is engagement. To hear peoples’ stories, to be listening, hearing, empathizing and believing. And as the issues arise, we need to talk and work through these patient issues. We need to believe the stories and have government and politicians hear those stories.
- We do not yet know how exactly we will do engagement and that is what we need to hear from you, but we know that is not just about talking to leadership and health directors but talking to community members and front-line workers. We know that it means visiting and engaging on an ongoing basis - not just a few visits. This will take a few years.
- We also need to talk to providers and policy makers – and this is just the beginning.

### **Wally McKay**

Wally emphasized the need for health transformation to be done by the people. If NAN or health authorities do it, it will fail. It has to come from the people. We are fighting for equity, but we can go even further than that, as we have our own traditional medicines and spirituality that can make us even stronger and healthier than the rest of Ontario. In the meantime, we need to think outside the box on what will make a difference on the immediate needs.

### **Small Group Discussions – Immediate Issues**

The delegation broke out into six facilitated groups of approximately 8-10 people. Two sessions were held whereby each group discussed the following:

- What are the immediate issues?
- How do we address and prioritize the immediate issues?

The group reports are synthesized into the following immediate issues:

## ***Mental Health and Addictions***

- Treatment for youth (facilities, family treatment, Form 1 beds).
  - No Form 1 beds in Sioux Lookout (only 8 beds in Thunder Bay).
  - Many delays resulting in time limit of Form 1 being surpassed and becoming obsolete. They then have to start the process over or they leave out of frustration.
  - Acute mental health beds.
  - Need to increase psychiatric assessments at the community level.
  - Safe Houses in communities are required.
  - At-risk youth require 30-60-day healing program that should be instantly accessible to anyone presenting with suicidal thought or attempt.
  - Youth mental health and addictions centre.
  - Land-based and family approaches.
  - Establish safe places – culturally responsive facility or lodge for youth (mental health/addictions centre with aftercare).
  - Adolescent mental health ward/unit.
    - Ongoing presence of Elders (at the discretion of families).
- Increase number of homes and transitional homes.
- Specialized training (addictions, trauma, concurrent, violence, etc.) – increased specializations and increased training options for community workers.
- Increase psychologist and psychiatrist access.
- Review of crisis team model.
  - Appropriate and prompt crisis response in communities.
  - Identifying and making referrals to specialized services and after care for people who are discharged.
  - Address crisis costs including flights, expenses, funeral costs, etc.
  - Look for options for communities to have appropriate crisis funds.
- Debriefing and supports for mental health workers is needed.
- Case management and discharge planning.
- Confidentiality requirements sometimes create barriers for families and communities providing supports and ensuring follow up.
- After care and continuity of care.
  - Mental health workers should stay for at least 3 months to ensure continuity and build trust (Currently, they come for 5 days at a time and do not provide reports on who they see so there is no follow up).
  - Could have residences available for providers with families.
- Need to address root causes of addiction and sexual abuse (e.g. intergenerational trauma, colonization) on a gradual basis.

- This requires wholistic healing strategies developed by our people, including Elders, to look at the consequences and healing process.
- Leadership needs to be involved and men need to be involved to look at family and community roles.
- This will involve getting everyone together in the community to deal with drug dealers and addictions and work together to support families as they deal with addictions.
- Family approach – workers need to relate better to the family situation and workers need to get to know community members better.
- Appropriate Suboxone program with aftercare in each community that focuses on helping people come off Suboxone, based on real community data and needs.
- Cultural and land-based approaches.
- Community healing approaches based on choices of the community.
- Mental health workers should draw on the strengths of Elders, program people and community workers to work together to supports clients.

### *Access to Specialists and Allied Health Providers*

- Access to physiotherapy, occupational therapy, speech pathology, ear nose and throat specialist, rehab, mental health specialists, etc.
- Improve dental access and care (currently, there are insufficient dental days and extraction is the norm).
- Pharmacy
  - Access to pharmacist and pharmacy technicians so that people have a place to go to ask questions and receive follow up.
  - Timely delivery of medications (there are many delays, limited refill timeframes, and it is common for patients to skips several days of the medication or to have to go to the nursing station daily until the shipment arrives).
  - Elders are having to pay for their medication.
  - Often only generic or cheap versions are approved.
    - We need to be involved in decision making.
- To improve access to organ donations – it was suggested that a NAN-wide Live Donor program be developed.

### *Increased Access to Physicians and Nurses*

- Nurses
  - Develop NAN nurses rather than nursing agency.

- More First Nation nurses.
- Relationship with community.
  - Proper orientation.
  - Aware of community needs/protocols.
  - Communities hire their own nurses.
  - Continuity of care (less parachuting).
- Standards of care and clinical practice guidelines (treatment plans, proper assessment, access, etc.) – currently people make repeated visits to clinics and are not properly assessed and sent home with Tylenol.
  - Standards of care – who is accountable?
- Nurses need to take concerns more seriously.
- Cultural safety training.
- Need increased Nurse Practitioners for roles such as diabetes management.

➤ Increased physician days for each First Nation.

## *Diabetes*

- Dialysis.
  - Dialysis is needed in the communities.
  - There is a lack of children’s dialysis – it is not even available in Thunder Bay.
- Foot care is often accessed when it is too late. There is a need for more promotion and education to ensure earlier intervention.
- Prevention.
- Education.
- Supports.
- Nutrition and healthy living.

## *Elder Care*

- Palliative Care.
- Long Term Care Facilities.
- Various housing options (assisted living, transitional housing, Elders’ complex, etc.).
- Chronic Continuing Care Beds (currently residing at WAHA Hospital, but only funded for beds, not other services such as recreation, programming, etc.).
- Alternate Level Care options.
- Home Care (funding formulae outdated – based on 1997 population statistics).

- Respite Care.
- Aftercare and rehab supports (physiotherapy and occupational therapy).
- Training for families to provide supports to elderly.
- Elder abuse awareness.
- Geriatric services.
  - Geriatrician (looks at senior's brain, dementia, Alzheimer's, etc.).

## *Maternal Health, Early Years and Child Development*

- Special Needs Children.
  - Rates of developmental delay is increasing, but there are no supports in communities.
  - Respite and supports for families of special needs children.
    - High autism rates – we need appropriate supports and ensure families have supports and education.
  - Training and supports in schools.
  - Diagnosis and assessment.
  - Funding for children with disabilities gets cut off, but families need more time to prepare and transition.
- Midwives and maternity care/supports.
- Breastfeeding promotion and supports.

## ***Screening, Prevention, Early Identification and Public Health***

- Diabetes programming.
- Life skills.
- Cancer.
- Dental prevention.
- Early identification and screening (TB, mammograms, cancer, etc.).
- We should ensure everyone is getting their annual check-ups and that it is made a priority.
- Diagnostic equipment (x-rays, etc.).
- Exercise and nutrition.
- Social determinants of health.
- Public Health and Health Promotion (nurses and public health educators).

## ***Case Management and Client Coordination/Supports***

- After care, follow up, continuity of care.
- Case management.
- Discharge planning.
- Patient advocates and navigators.
- Cultural workers.
  - Ensure communication is in place with the nurses.
  - Ensure follow up.
- Medical training for translators.
- 24/7 translation services in medical centres.
- Hostel in Sioux Lookout – sometimes wait for hours.
- Adequate data and information/record sharing to coordinate services and have case management.
- There is a need for family health care navigators (community based and familiar with the system).
  - Advocacy and support for families.
- Patient navigators/advocates in communities.
- Client focused health care.
  - Customer service approach and training – general attitude of helping and no-wrong door approach.
- Treatment options

- Follow up on medications.

## ***Emergency Response***

- Medivacs
  - Timely response (currently takes 2-5 hrs or longer).
  - Review restrictions (weight limits).
  - Orgne has restrictions preventing mental health supports accompanying people being medivaced for mental health issues.
  - Sometimes children are having to travel alone.
- Ambulance services and facilities.
- Community-based first response (First Aid, Rangers, CPR).

## ***Food Security***

- Gardens and greenhouses.
- Children's nutrition.
- Cooking skills, food prep.
  - Have crockpots and blenders to loan to parents and then return every week to share ideas.
- Harvesting (berry picking).
- Hunting, fishing, trapping.
- Community freezer.
- Food program (revamp Nutrition North program).
- Support people to become more self-reliant by teaching skills.
- Addictions plays a role in parents not providing adequate food to their children – teachings around cooking, addictions and parenting can be combined.
- Encourage parents to bring children to programs and have activities for their children to increase parent-child connections.

## ***Infrastructure***

- Office space (including training space).
- Lack of space for health staff to deliver programs and supports to the community.
- Information Technology (internet, private lines, telemedicine, EMR, data).
- Diagnostic equipment.

- Long-Term Care facilities and chronic care beds.
- Facilities for ambulance care.
- Nursing stations.
- Province and Federal Government both on board – aligning processes for new models.
- Improve hostels and accommodations for people travelling to services.

### ***Data and Electronic Medical Records***

- Support existing data initiatives such as Mamow Ayhamowen (data partnership).
- Mustimuhw Solution Services (Community Based EMR) funding (supports case management).
- Population health information to inform planning and community priorities.
- Need electronic records.

### ***Water, Housing and Poverty***

- Address overcrowding and living conditions (including mould).
- Ensure access to clean water and proper sewage.

### ***Health Human Resources and Capacity Building***

- Expanded scope and specialist training for providers such as doctors and nurses (support systems and incentives in place).
- Retention initiatives.
- Longer term contracts.
- Grow your own health care providers (i.e. Nurses, pharmacists, paramedics, mid-wives, pharmacy technicians, lab technicians, traditional healers etc.).
  - Start early with students (co-op programs, role models, and mentorship).
  - Support existing providers to upgrade their designation (PSW to RPN to RN to NP, etc.).
  - Work with Oshki Wenjack to develop programs for our own people (PSW, RPN, dental, mental health, traditional medicines, speech etc.).
- Elders to teach and sit on the faculties of colleges and universities.
- Training strategy and mentoring plan for new and existing community workers.
- Mentorship and training for traditional workers (for communities that want it).

## Non-Insured Health Benefits

- Escorts
  - We should be looking at different escort models, including:
    - Compensating escorts for their service and support.
    - Training for escorts (e.g. taking temperature, blood pressure, blood sugars, medical terminology, etc.).
- Travel
  - Indigenous rights to transportation (imposed boundaries such as zones, jurisdiction, treaties, etc. hinders urgent care needs).
  - Last minute travel (sometimes receiving travel notification the day of or even an hour before their flight).
  - Long wait times, uncoordinated times, and indirect routes result in long days (sometimes getting in at 3:00 am) which is unacceptable for Elders.
  - Opportunity to develop our own transportation program.
  - Challenges specific to road access communities:
    - Highways need to be better maintained.
    - NIHB transportation is frequently in deficit so program funding often used for transportation when it could be used for programming.
    - Once people are in cities they do not know where to go or what to do.
    - Policy restrictions preventing claims to be made based on distance from doctors.
    - Education required on the options for travel.
  - Fly-in Communities
    - Milk-run flights are challenging for Elders and injured or disabled patients.
    - There is no certainty that the patient will get to their destination, people get bumped resulting in children having to travel on their own.
  - Need to increase access to travel grants.
- Drug Benefit formulary – generic versions, disparity compared to provincial formulary and uncovered costs.
- Pharmacy (see specialty services above).
- Birth registration and health card registration.
  - We need a liaison advocacy service to assist with completion of forms.
- Dental.
- Eye exams.
- Jordan's Principle still not fully addressing issues as intended and as reported by Department of Indigenous Services Canada (DISC).
- NIHB does not cover traditional healing services.
  - Limited number of traditional healers – budget is to access the healers.
- Take over NIHB.

- Options and flexibility for patients on how they want to be treated.
- Problem with interpretation of “nearest, appropriate facility” restriction (only looking at nearest - not quality and accessibility of services that are available).

### ***Legislation, Policy and Funding***

- Protection of Treaty Rights.
- Alignment of funding and breaking down silos.
- We should be enhancing what works - rather than creating new programs.
- Flexible funding.
- Outdated and inadequate funding formulae (Home and Community Care – based on 1997 population figures).
- Impacts of geography (remoteness).
  - A NAN specific Consumer Price Index (CPI) is needed.
- Key areas of legislative and policy reform:
  - Nursing
  - NIHB/Access
  - Public Health – Medical Officer of Health
- Develop a comprehensive plan from all First Nations partners (First Nations, Tribal Councils, NAN, Chiefs of Ontario) and a way to share information that we have to inform the legislation including a wholistic approach and ensuring that culture and language are the foundation.
- Services and access for off-reserve members.

### ***Wholistic Approach with Culture and Language as Foundation***

- Traditional healing options.
- Land-based approaches.
- Wholistic and multi-sectoral (breaking down silos).
  - Education, Social and Health need to work together.
- Culturally appropriate assessment tools.
- Cultural safety training (currently, there is judgement, discrimination and stereotyping, including from our own people).
- Clinical guidelines need to be more flexible to include First Nations input into care.
- Use of traditional medicine to get healthy without pills.

- Recognize traditional healing.
- Traditional food access in hospitals/hostels.
- Hiring protocol for patient care assistants to speak the language.
- Spiritual supports and traditional medicine should be more accessible.
- Translation
  - More translators available – should be regularly available in all medical centres.
  - Training for escorts on anatomy terminology.

## *Governance and Structure of Health System (Community Structure & Regional Structure)*

- Capacity across the board (training, decision making, funding mechanisms).
- Direction from elders.
  - Strategies to preserve elder knowledge.
- Communication/engagement strategies.
- Partnerships at all levels working together.
  - Systems analysis.
  - Networking to share between communities to share ideas and what we have (i.e. procedures and best practices).
  - Develop a system whereby roles and responsibilities are clear at all levels (community level, regional level and political level).
  - The political level is where advocacy work for legislation and include partnerships with organizations, universities, colleges and service providers needs to take place.
  - Look at different models that are working (BC Model, Halifax model, Alaska, etc.).
- Community Level
  - Vision developed at community level.
  - Community restructuring to break down silos.
  - Local governance and health systems.
    - Separate local politics from administration.
    - Review workloads.
    - Develop a vision at the community level.
  - 5 Year Work Plans (Strategic Planning) at community level.
    - Case Management.
    - Health Director brings new initiatives to Chief and Council, followed by a meeting and community engagement.
    - Data.
    - Direct Services.
- Regional Level

- Alignment of funding dollars (enhance what is already working).
- Direct service funds for planning.
- Technical services to support communities.
- Need to support existing processes.
  - Wabun: home and community care, long term care, Mustimuhw Community-Based EMR.
  - Matawa: Health Co-Op Plan.

➤ Political Level

- Legislation.
- Allocation formula.
- Education, Training and Advocacy.
  - University & College Partners.
  - Support Training.
- NIHB and Jordan's Principle.
- Infrastructure and Capital.
- Break down silos at NAN.
- Certification and accreditation standards for health professionals.

## Prioritization

Groups were asked to prioritize the immediate issues. Each group took their own approach to prioritization. However, comments were made on the challenges of prioritization with the following key points being shared:

- All priorities are important as it comes down to the overarching priority being the people themselves.
- Priorities are different from community to community.
- It is difficult for communities to prioritize when they are in crisis.
- We should not need to prioritize when we are talking about basic needs.

A survey was also distributed to prioritize the immediate issues raised from the previous discussion. Given the diversity of issues as well as the diversity of approaches, it is difficult to generalize; however, the following five priorities are generally consistent among groups and the survey results:

- Mental Health and Addictions
  - Youth and family treatment
  - Aftercare
- Infrastructure (water, housing, space to provide services)
- Elder Care and Long-Term Care
- Addressing NIHB issues
- Funding mechanisms

The following represents a more detailed breakdown by group and describes their particular approach to prioritization:

**Group One**

Group One distilled the top two priorities as being legislation and infrastructure. With regards to capital, the priority is nursing stations. With regards to legislation, the group described the need to have a comprehensive plan from all (First Nations, Tribal Council, NAN, COO, etc.) and a way to share information that we have to inform legislation and ensure that is founded upon a wholistic approach and that culture and language are the foundations in all aspects. Areas requiring legislative and policy solutions include: NIHB, nursing, Public Health - Medical Officer of Health (MOH).

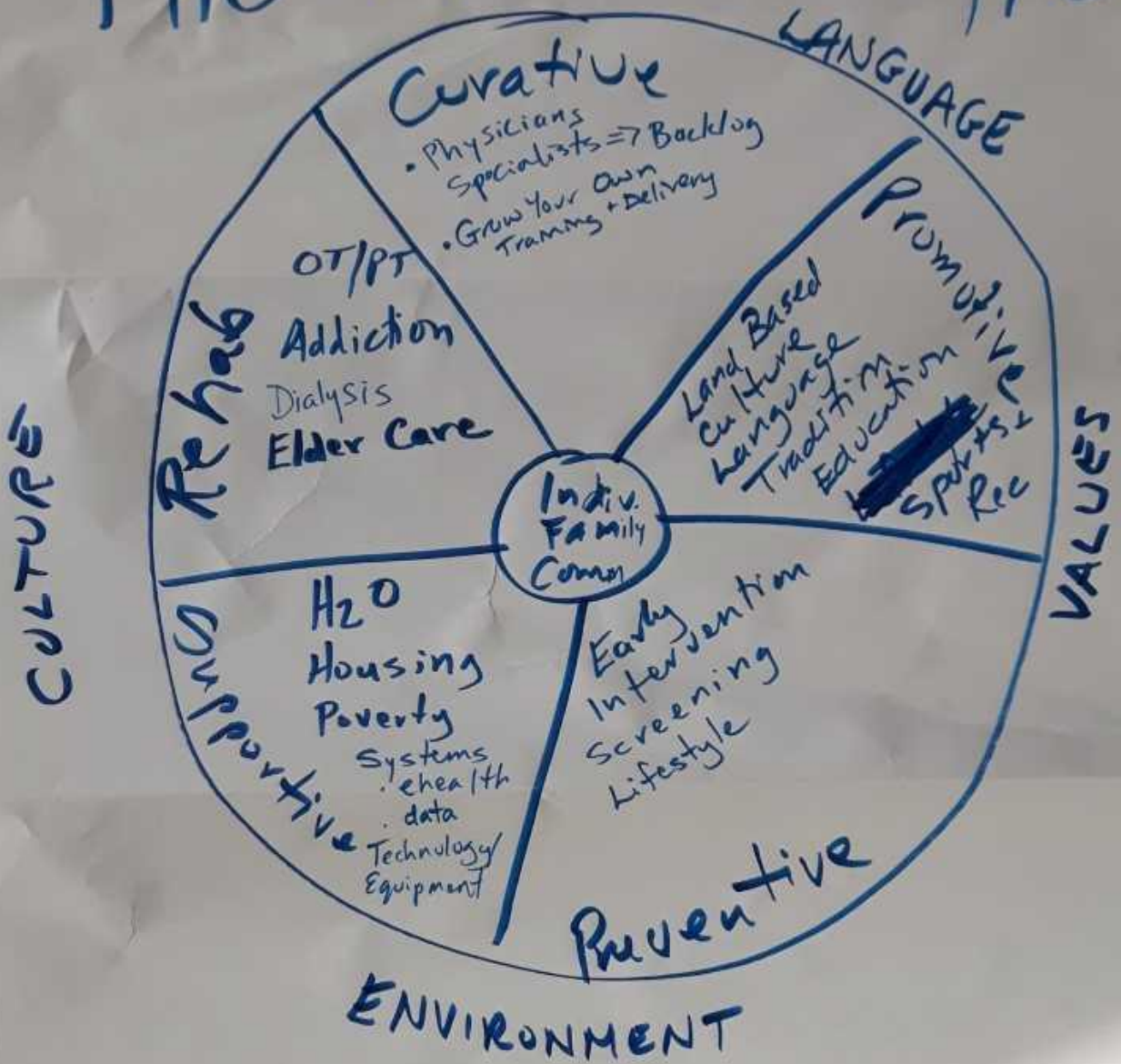
**Group Two**

Group Two took their list of immediate needs and asked each person to place items in their top 4 priorities:

<b>#1 Priority</b>
<ul style="list-style-type: none"> <li>➤ Youth at Risk Facilities</li> <li>➤ Addictions</li> <li>➤ “Grow your own” training for health professionals and community workers.</li> <li>➤ Access to specialists</li> <li>➤ NIHB Agreements               <ul style="list-style-type: none"> <li>○ No increase</li> <li>○ Not enough money to meet needs</li> </ul> </li> <li>➤ Housing</li> <li>➤ Poverty</li> <li>➤ Impact of geography – lack of services in community</li> <li>➤ Backlog of patients to see physicians.</li> </ul>
<b>#2 Priority</b>
<ul style="list-style-type: none"> <li>➤ Water</li> <li>➤ Early Identification of diseases and screening and surveillance</li> </ul>
<b>#3 Priority</b>
<ul style="list-style-type: none"> <li>➤ Cancer</li> <li>➤ Diagnostic equipment.</li> <li>➤ Diabetes</li> </ul>
<b>#4 Priority</b>
<ul style="list-style-type: none"> <li>➤ Gardening</li> </ul>

They then took their priorities and placed within the NAN Chiefs Primary Health Care Model (mandated by NAN Resolution 90/10) below.

# PHC Model - Res. 90/10



#

### **Group 3**

Group Three took their list of immediate issues and collectively identified the ones that were top priority (in no particular order):

- Data on patient experience.
- Long-term care facilities.
- Dental.
- Birth registration.
- NIHB.
- Better communication.
- Case management and discharge planning.
- Mental health and addictions.
- Drug prevention (security and searching capacity for planes, trains and ice roads).
- Cultural safety training.
- Aftercare.
- Health Human Resources - Grow our own health providers.
- Respite.
- Engagement (the sooner the better) – recommend 1 person at each Tribal Council.
- Nursing services.
  - Cultural safety training.
- NAN-wide Live Donor Program.
- Funding
  - Carry-over into new year.
  - Examine funding formula.
  - NAN-specific Consumer Price Index (CPI).

### **Group 4**

Group Four identified the challenges in the prioritization exercise as they are different from community to community in terms of needs and in terms of readiness and planning as impacted by states of crisis. Each member of their group identified their top priority with the majority being related to mental health and addictions.

- Transportation (medical).
- Breakfast program/proper nutrition.
- Mental health and addiction (2 responses).
- Roots of addiction.
- Mental Health Workers.
- Youth & Family Treatment – 60-day program.

### **Group Five**

Group Five took the list of immediate items from the morning discussion and prioritized their top 15 items.

1. Space/Infrastructure.
2. Mental Health and addictions.
3. Screening and prevention.
4. Take-over NIHB.

5. Elderly care (in every community).
6. Training-capacity building.
7. Housing.
8. Clean water.
9. Dental.
10. Patient navigators/advocates – community workers.
11. Specialized services.
12. Nursing.
13. Traditional.
  - Cultural renewal.
  - Land-based.
  - Community choice (abide by community protocols).
14. Under-funded programs.
15. Medical emergencies.

**Group Six**

Group Six prioritized the immediate issues by listing the following top priorities:

- NIHB.
  - Declining number of escorts available.
  - Travel for Elders.
- Mental Health.
  - Suicide.
  - Addictions – more community based trained workers.
- Negotiations with Health Canada.
  - Funding formulae.
  - Contribution Agreements.

In order to further assist with prioritization a survey was distributed and filled out by 33 of the participants. Of the respondents there were: 16 First Nation Health Directors, 3 Tribal Council Health Directors, 4 Service Providers and 10 other. The results highlighted the following top 20 priorities based on the percentage of respondents that indicated the priority as critically important to the health system transformation process. Full results are found in Appendix A.

PRIORITY	% of respondents who indicated that the priority is critically important to the health transformation process.
Suicide prevention, intervention and treatment services	88
Legislation and Policy – new and amended	81
Community Infrastructure – housing, water, sewer, etc.	81
Community Input into the Process	81
Multi-year funding	75

Working together with First Nations, Tribal Councils, NAN, as well as COO, AFN, Service Providers, First Nation regional organizations	72
Addressing NIHB issues (access, transportation, escorts, pharmacy, dental, vision)	72
Mental Health	72
Community education and awareness about Health Transformation	69
Early diagnosis and intervention for disease and mental health issues	69
Protocols and structures for bringing community concerns to the negotiation table and for reporting progress	66
Diabetes	64
Land-Based Healing	64
Equitable allocations formulae based on community need	63
Alignment of funding at all levels	63
Health Service Delivery Infrastructure (offices, examining rooms, equipment)	63
Recognition of traditional healers and equal compensation for their services	60
Use of traditional medicines	60
Standards of care	60
Special needs identification, assessment and treatment	60

Survey participants were also asked to identify the timeframe for priorities as immediate, medium and long-term. Over half of the respondents agreed that the appropriate time frame for addressing the following 15 priorities during the health transformation process as “immediately”.

<b>PRIORITIES</b>	<b>% RESPONDENTS</b>
Community Input to the process	85
Community Infrastructure – housing, water, sewer etc.	78
Working together with First Nations, Tribal Councils, PTO (NAN), as well as COO, AFN, Service Providers, First Nation regional organizations	75
Community education and awareness about health system transformation	69
Suicide prevention, Intervention and Treatment services	66
Legislation and Policy - New and Amended	66
Early diagnoses and Intervention for disease and mental health issues	66
Equitable allocation formulas based on community need	63
Addictions	60
Land-base healing	60
Mental Health	60
Protocols and structures for bringing community concerns to the negotiation table and for reporting	60

Diabetes	57
Health service delivery Infrastructure (offices, examining rooms, equipment)	56
Multi-year Funding	54
Addressing NIHB issues (access, transportation, escorts, pharmacy, dental, vision)	51
Trauma Informed Care	51

**Wes Nothing – Personal Journey of Reversing Diabetes with Nutrition**

Wes Nothing, Health Director from Bearskin Lake First Nation, shared a video that was created describing his journey to healing diabetes through nutrition. He described how he lost weight through juicing and cutting out foods that are high in combined carbohydrates. He initially lost 60 lbs in 90 days and through continued dedication he was eventually able to eliminate the many prescription medications that he was previously taking.

His video, which was produced by the SLFNHA, can be found online at: <https://www.youtube.com/watch?v=fZ2QEgJil98>

# DAY 2

**Large Group Discussion on Health Transformation**

A plenary session was held in which there was a large group discussion about the health transformation process. Participants had questions about the process such as:

- How will existing work be included in the process?
- How will people on the ground be kept in the loop and have a say in the process?
- How will it support existing work of Tribal Councils and Health Authorities?
- It was recommended that a Chief from north of Sioux Lookout be included in the Chiefs Council.
- Concern that there would be sufficient resources to continue the process to completion.
- It was recommended that engagement begin as soon as possible.
- How will this process support and link with other processes such as TFNSOC, Keewaytin Table, 4 Party Table, etc.?
- How will the NAN Health Advisory Group (HAG) be involved in the process?
- How do we align new resources (Family Well-Being program, Choose Life, Jordan’s principle) and work to enhance existing programs that are already working?
- How will information from the Health Directors be used?
- What will be presented to the AFN meeting?

**RESPONSES**

The following responses and comments were provided by Sol and Ovide:

### **Chiefs Council on Health Transformation**

- The Chiefs Council was selected by leadership at NAN and the members are to represent all of NAN and not their specific Tribal Council area. That being said it is important that the membership reflect the diversity of NAN. A Chief from north of Sioux Lookout has now been confirmed to participate on the Chiefs Council.

### **Partnerships and Working Together**

- It is early in the process and NAN is still working out how all the partnerships will work and how we will work with Health Authorities, physicians, hospitals, etc.
- We will work with Keewaytin Table, Tribal Councils, Health Authorities, we are not going to come and tear down what you have built.
- We need to work together. We will have to ask hard questions and we have to ask them to ourselves. As we move forward we will be asking them. We have Health Authorities, Tribal Councils and communities. They happened because Health Canada wanted them to happen and we are competing for resources in every area. The conversations from yesterday were really encouraging.
- Ovide shared the experience of an Elder that said there is a shadow that comes and is the cause to a lot of these problems, but the Elder said, “the evil spirits cannot stand in the light of the creator, I am protected, I can do anything because I have faith.” As a group of people, we have a greater power that liberates each other and a faith that we can work together. I have a strong faith in our people and I believe fully that we can do it in our lifetime.

### **Joint Action Table (JAT)**

- The JAT was at the Assistant/Associate Deputy Minister (ADM) level and it was more technical – we had SLFNHA, WAHA and Matawa as part of the process. We have not met since before the Health Summit as we are in the process of establishing a new Appendix A to the Charter, the Joint Health System Transformation Table Terms of Reference and determine how the JAT will link with that.

### **Resources**

- NAN hopes to notify the Tribal Councils and leadership on the upcoming resources within the next couple weeks.
- The Grand Chief Alvin Fiddler and Minister Jane Philpott will be meeting during the first week of March to talk about the 2018-19 budget, which will guide us for next year and the following years.
- We are working to align programs such as Choose Life, Jordan’s Principle and Family Well-Being and streamline the funding mechanisms.

### **Goals of Health Transformation**

- This process is about major reforms as outlined in the Charter, but also to recognize there is a disparity in NAN territory. Many have suffering that cannot compare and there are enormous gaps in services that are resulting in deaths. We want to end that kind of suffering and do it in a way that is inclusive with everyone involved. Therefore, we are gathering here today.
- We have 150 years of colonization that we are addressing and the disparity is evident. We need to address the gaps and make sure services are accessible to our people. That is why we have this process – to close the gap. We are not satisfied with what we have, and we encourage you not to be content with the changes you have made but to go beyond that.
- We want to lift our people up and the only way is to cooperate and to share. Not everyone is at the same level, so we want to share advancement from one area to another. We need each other. We want to share knowledge between us and doctors and nurses, etc.
- This process is not about the health care system, the Indian Act or legislations, it is about us – about who we are. “Act Indian – not Indian Act”.
- We will talk about laws – we need to change their laws which do not recognize and respect our Treaty Rights, self-determination and our own jurisdiction to create our own institutions. There is only so much we can do in the existing system – we need to go beyond, we want full inherent authority.
- We have to build the capacity to build the best system. We can look to others, such as BC, but we have the brilliance to create something better.

### **Engagement**

- We will consult with everyone: Chiefs, Council, Women, Men, Youth, Elders, etc.
- We do not want to overstep – so if you are happy with your process we will enhance it. We applaud the progress, but we can make even more progress together. We have to be creative as a people to create action that allows our people to be well, to get better as a people to make sure we are healthy.
- We will engage every community in a respectful way and will always request the consent of the leaders. We will go to the grassroots people and find out directly what concerns them about nursing stations, suicide, diabetes, etc.
- We make a commitment to you that no one is forgotten and that we will involve everyone. Any negotiation involving regional issues will have a Chief from that area present and fully involved in the negotiations.
- We would like to see projects come forward to have a community, say what they would like to see and if there is a group of communities with the same project (e.g. dialysis) then we will all work together.

## Small Group Reports

On Day two new groups were formed and organized based on commonalities. This was done in order to distinguish the different perspectives:

- **Community Health Directors** were grouped with other communities in their region which served to provide a regional perspective and also a generalized grouping based on whether they are road access or remote fly-in community.
- **Tribal Council Health Directors** were grouped together into one group.
- **Health Authorities** - representatives from the Health Authorities (SLFNHA and WAHA) were grouped together.

Groups were comprised of the following:

Group One	Tribal Council Representatives
Group Two	NAN West 1 (Community Health Directors from INFA, KO and Windigo Communities)
Group Three	NAN West 2 (Community Health Directors from Shibogama communities and the HD from Bearskin Lake First Nation)
Group Four	NAN East & Central (Community Health Directors from Wabun and Mushkegowuk Communities)
Group Five	SLFNHA and WAHA representatives
Group Six	Community Health Directors from Matawa Communities.

## What Does Health Transformation Mean to You?

In describing what Health Transformation means to them, several groups spoke to the importance of translating it into the language. One group used the term *Kay an chii sek*, meaning something that is changing and evolving as the term describes the state of change itself. Sol used the term *Mushkiikiw mamiinaachiikaywin* with *Mushkiikiw* meaning “medicine or health care” and *mamiinaachiwaywin* meaning changing something to its proper order.

The responses from all the groups are summarized into the following themes:

### *Healthy Communities and Ownership over Health*

Participants described transformation as leading to healthier people, families and communities. It was described as a process to change mind-sets for taking individual ownership over one’s health:

*Believe you are the expert in your health care, you are a partner in your care – you must be accountable, and you can change the system.*

### ***First Nations Self-Determination and Jurisdiction***

Consistent among all groups was the need for transformation to lead to First Nations Self-Determination and Jurisdiction. This must include:

- Legislation such as a NAN Health Act.
- Funding mechanisms that reflect a nation to nation relationship.
  - Not to come from Treasury Board (or government departments).
- A foundation that is based on the Treaty Rights, including the Treaty Right to Health.
- Accountability to our people.
- First Nations governance and management over our health services within our own areas.

It was also noted that jurisdiction needs to include off-reserve members as some communities have half their membership off-reserve. We need to help the urban system to reform and provide navigation, services, support, etc. to those members.

### ***Treaty Right to Health and Federal Fiduciary Responsibility***

Participants made it clear that the vision going forward must be founded upon a recognition and acknowledgement of the Treaty Right to Health and the Federal Fiduciary Responsibility for First Nations health. This would include:

- Recognition of NAN's uniqueness that the Treaties were signed with Canada and Ontario.
- A clear outline of jurisdiction/responsibility.
  - We would not need Jordan's Principle if we had jurisdictional clarity.
- Definition of health based on Treaty Right to Health and interpretation of the Treaties.
- Sharing of the resources from our lands (other Treaty Partners have benefited from the Treaties, but we have not as resources have not been shared and inequality exists).
- New funding and reporting mechanisms.
- Development of our own policies based on what works for us.

### ***Community Control***

Central to health transformation is the increased community control and decision-making over services within the community and over regional services and funding allocations. This would include:

- Communities to be able to hire their own doctors and specialists or have a say in the hiring.
- Communities making their own decisions.
- Sustainable and flexible funding models which include:
  - Needs-based funding (including impacts of remoteness/geography).
  - Based on community priorities - communities know what they need.
  - Increase direct funding to communities.

- Increase flexibility (lift restrictions and allow for carry over into new fiscal year).
  - Cost savings to be invested back into community programming (e.g. cost savings resulting from the introduction of the Prescriptions Monitoring Program).
  - Funding based on long-term commitments.
- Reporting models that reflect a nation to nation relationship with accountability to the people being the primary focus.
  - Streamlined reporting.
  - Reduced bureaucracy.
  - Regional services reporting of health outcomes and quality improvement plans to communities.
- Community Health Plans to be updated to reflect current realities.
- Concerns about off-loading or being locked into something.
- Programs to be designed and driven by the community.
- Programs and services that meet community needs.

The transfer communities from Shibogama described the lessons to be learned from the transfer experience: even although there is increased control they described being locked into outdated funding agreements, which does not evolve with the communities needs and increased rise in costs.

### ***Capacity Building and Health Human Resource Development***

Groups consistently identified the need for our own people delivering services as they know what the needs are and how care should be delivered. Key points include:

- Promotion of health careers among the youth including:
  - Career development
  - Job shadowing
  - Summer placements
  - Mentoring
- Increased training and supports for front-line workers.
- Promotion of health management and administration careers.
- Work with education institutions.
- Ensure supports are in place to support communities (funding, expertise, mentorship).

### ***Equitable Access to Services & New Models of Care***

Throughout the transformation process, we should be focused on increasing access by ensuring that services are available when needed and that we are striving towards equity in services and in health outcomes. Key points include:

- Increased access to nurses, doctors and specialists.
- Address gaps in services.

- New nursing models
  - Bring back Northern Clinical Training Program.
  - Increase clinical training of nurses.
  - Learn from different models including the work of Tribal Councils (KO and Matawa).
- Mechanisms for second opinions.
- Traditional healing options.
- Client coordination supports.
  - Patient navigators or liaisons are needed to improve access, case management and discharge.
- Build strong and ethical teams through mutual understanding and respect of care delivery.
- First Nations run pharmacy.
- Add health worker positions in community (e.g. Lab Technicians).
- Midwifery.
- Accountability to the people.
  - Quality improvement frameworks based on data, measurements, targets, etc.
  - Change the cause of “bad outcomes.”

### *Wholistic Models of Care & Restoring Community Wellness*

- Make wellness a priority of health providers (separate wellness issues from urgent issues).
- Community wellness (e.g. community gardens).
- Research on plants and herbs and ways to pass on the knowledge.
- Recognition of traditional medicine/doctors.
- Rebuilding wellness – looking at what we had and how we used to be.
- Social Determinants of Health (housing, water, food security, education, etc.).
- Recognition of traditional medicine and healing practices.
  - Respecting choice.
  - Integration into the system.

### *Communication and Coordination*

- Understanding roles and responsibilities, working relationships and linkages (NAN, Tribal Councils, communities, government, Health Authorities, service providers etc.).
- Cross-Sectoral linkages.
- Communication at all levels.

### **How do we Implement Health Transformation?**

Groups discussed the implementation of health transformation. One group gave an overarching comment of “Just do it!” The following themes emerged from the group discussions:

### ***Knowledge Transfer and Best Practices***

- Develop a knowledge sharing system to learn from each other and from best practices.
- Study other models (Study other models (Alaskan Nuka Model, Halifax, New Zealand Aborigines).
- Enhance what is working and change what is not working.
- Look at other processes within NAN (Education and Child Welfare).

### ***New Models of Care and Increase Access***

- Hubs across NAN for hospitals and long-term care until available in other communities.
- Case management.
- Develop models that are suitable to each community.

### ***Wholistic and Land-Based Models***

- Land-based, cultural activities.
- Traditional practices of medicine and healing as part of the system.
- Revive the language.

### ***Address Funding and Reporting Barriers***

- Develop new funding mechanisms.
- Streamline reporting.
- Develop funding/budget for each community - based on their unique needs.

### ***Coordination and Partnerships***

- Training and strategic planning at Tribal Council and community level.
- Coordinated capital plans.
- Coordination between sectors, levels and services. – break down silos.
- Everyone needs to be involved (community members, leadership, hospitals, all ministries, etc.).

### ***Communicating the Health Transformation Process***

- Develop visual models.
- Develop action plans etc. (Put the process into writing).
- Set a timeline of goals.
- Networking and coordination with all concerned.
- Need to see progress and follow-ups throughout the process.
- Set a timeline of goals.
- Develop a slogan.

### ***Foster Change at the Individual and Community Level***

- Educate all (children, youth, elders, parents) regarding transformation.
- Involve youth in decision making.
- Look towards future and change mentality from past experiences (i.e. 60s scoop).

### ***Advocacy and Supports for Patients***

- Develop a network of navigators.
- Ombudsman/spokesperson to speak for patients.

### ***Governance and Jurisdiction***

- Implement a NAN Regional Health Network (LHINs).
- Health government for NAN territory for oversight of governance and management issues.
- Creation of our own legislation.
- Use the economic spin offs to build our institutions.

### ***Build Capacity***

- Develop our own education institutions.
- Develop a supportive structure for communities.
- Through education and part of the curriculum.
- Partnerships with training institutes.
- Youth internship/job shadowing.

### ***Support Existing First Nations Models***

- Tribal Councils and Health Authorities spoke to the importance of supporting existing systems in Tribal Councils and Health Authorities and developing a structure for implementation (primary care, clinical services, human resources, public health, home and community care, standards, etc.).

## **How do you see engagement and communications happening in and with your communities?**

Groups discussed how they would like engagement and communication to occur in and with their communities. The results from all groups and survey responses (Appendix A – Question 3 & 4 regarding communication and feedback processes) were synthesized into the following points:

### ***Engagement Methods and Approaches***

- There was consensus that community engagement must be an ongoing process with multiple opportunities to participate, including multiple community visits.
- Language is critical and must include all dialects and all communications must be translated into different dialects and in Roman Orthography and Syllabics.
- Multiple methods should be used – the following were suggested:
  - Community visits (multiple times).
  - Radio.
    - Advertisements/announcements.
    - Live broadcasts of meetings.
    - Talk-shows.
  - Facebook, YouTube and other social media.
  - Email.

- Develop email distribution lists that include community workers, health directors, education directors, Chief and Council and other sectors to keep everyone up to date. Identify who will do this and how often they will send updates.
- Send updates and information directly to community members (can be done through un-addressed ad mail).
  - NAN website – section specific to Health Transformation.
  - Newsletter.
  - Posters.
  - Suggestion box in band office or nursing station.
  - Handouts.
  - Focus Groups.
  - Interviews.
  - Home visits/door to door.
  - Bingo.
  - Provide honorarium and other incentives.
  - Music and art (both receiving the message but also opportunities for youth to create messaging themselves through art).
  - Use small packages of information (e.g. short videos, etc.).
  - Enhance existing health plans.
  - Community needs assessments and community health plans.
  - Circles.
  - Working sessions.
  - Gatherings.
  - Feasts and events around food.
  - Health related career fairs.
  - Ongoing mechanisms to provide comment and submit ideas to the process.
  - Information booths and meeting and events.
  - Build upon previous reports and dialogues (especially over last two years) and engage on scope of work and the findings of these reports so they understand the scope of the work and can understand Health Transformation better.

### ***Whom to Engage***

- Patient experience (cancer, diabetes, youth mental health, etc.).
- Bring front-line workers together from different communities (e.g. Mental Health Workers, CHRs, etc.) – could be NAN-wide or regional.
- NAN negotiating team to meet with Chief and Council.
- Question and answer during Tribal Council, NAN and First Nation meetings.
- Bring Chiefs and Health Directors together again.
- Invite Tribal Council Health Directors to community meetings.
- Regular meeting with the NAN Health Advisory Group.

- Continue to invite the same people who were at the Health Directors meeting and keep them updated by conducting similar gatherings about health transformation at least twice a year.
- Talk to community health providers (nurses, doctors, educators, police, child welfare, etc.).
- Focus groups: youth, parents, Elders, etc.

### *Improved Communication*

- Clear communication from political level to operational.
  - Ensure front-line worker feedback informs resolutions that are passed and that they are aware of the impact of the resolutions.
- Gather information that governments have collected to be used by communities and included in the process.
- Provide reports in a timely manner.

### *Prepare Communities Members*

- Pre-visit planning.
  - Learn about local history, services etc.
  - Update and inform people first so they are clear on the process and what it is about – before asking for feedback.
- Ongoing updates
- Show examples of models.
- Provide a vision statement of Health Transformation.

### *Other points included:*

- Avoid using leading questions.
- Community visits should be multiple days with length determined based on size of community.
- Set targets on percentage of community members reached.
- Hit community interests (e.g. if a community wants an acute care unit in the community – target and support that and help them find funding).
- No issue or idea is too small.
- We need to build trust at all levels.
- Engagement needs to be done by people from the area.
- There needs to be consistency – same people presenting and being involved in the process.
- Consider timing (be aware of hunting/cultural weeks and any other events).
- Share draft documents.
- When engaging youth – bring youth workers along.
- Build capacity while doing engagement (provide ongoing support to communities).
- Engagement should be done in a timely fashion using all available resources (staff, communities, consultants, etc.).
- Timely feedback – rapid reporting and updating to communities.

- Validation of findings to ensure feedback was properly recorded.
- Messaging going out to all parties should be consistent.
- Engagement leads to planning and implementation.
- Provide daycare and rides to community meetings.
- Matawa has developed Health Co-op and would like funding to educate their communities through the Co-op.

With regards to allocation of engagement resources it was generally agreed that First Nations need community workers on health transformation. Tribal Council representatives were varied in their recommended approaches for the role of their Tribal Council. Some Tribal Councils recommended a project officer and a communication officer to work on community engagement, community information sharing as well as communication and liaison with NAN team, NAN Health Transformation Support Team and coordinators. Some Tribal Councils advised that they have to go to their Chiefs to see if they want Tribal Council workers. Other Tribal Councils would like to see the workers coordinated through NAN with flexible structures to support community engagement.

### How do we Effectively Use Existing Resources?

The following key recommendations were made with regards to how to effectively use existing resources:

#### *Improve Recruitment and Retention*

- Reduce turnover of staff at community health centre.
- Ongoing training and education.
- Wage parity, benefits and incentives.

#### *Remove Barriers to Using Resources*

- Remove existing barriers on how we use resources.
  - Alternative to contribution agreements.
  - Allow for carry-over into new fiscal year.
  - Eliminate flow through funding (turn the model upside down whereby communities flow funding to agencies to provide services).
  - Change accountability structures to reflect a nation to nation relationship

#### *Partnerships and Alignment of Resources*

- Economic partnerships (e.g. develop our own pharmacies and invest revenue back into the system).
- Different levels working together to maximize resources (AFN, COO, NAN, etc.).
- Determine who decides on resource allocation and priorities.
- Revise and update resources to meet community needs.
- Take stock of resources at the community, regional, provincial and territorial level. Reduce overlap, duplication and identify ineffective resources.

- Increase resources at the community level (it was noted that regional services are needed but there should be an increased focus on community services).
- Who decides on resources and who prioritizes?
- Look at other resources (e.g. Aboriginal professional associations e.g. nurses and doctors).
- Realignment of funding.
- Strategic Planning and Risk management (organizational level and umbrella broader level).

#### ***Traditional and Wholistic Approaches***

- Use traditional medicines more.
- Immediate recognition of traditional healers and traditional teachers.
- Include Elders in mental health, for example, including teachings with mental health wellness).
- Land-based approaches to healing.
- Need treatment centres that are close to home, land-based and involve families.

#### ***Support Existing Processes and Models***

Health Authority and Tribal Council representatives spoke to the importance of supporting existing regional planning processes and models and to learn from First Nations, Tribal Councils and Health Authorities that have started their own transformations. This includes:

- Establish long term commitments to support recent developments (data management, public health etc.).
- Increase resources for Tribal Councils and Health Authorities to continue with the work they have started.
- Using existing research and reports and not “reinventing the wheel.”
- Use technology to enhance existing services (upgrades are needed).
- Sharing information and working together (sharing proposals, information, best practices, etc.).

### **Next Steps and Closing Comments**

The delegation made the following recommendations to NAN with regards to the overall transformation process and the implementation:

- We need to implement the process right away – the sooner the better that we can get that information from our communities and to start engagement.
  - Negotiation and engagement teams to visit communities (create a presentation that the community understands and ensure Tribal Council Health Directors are invited to participate).
- Ask people questions and dig deeper, following up on their concerns and asking for solutions because you never know what answers you are going to get back.
- Provide communities and Tribal Councils with the resources to start transformation.

- Make sure that stories are acted upon immediately and that there is follow up and reporting back on issues that have recently been highlighted (e.g. Oxygen concentrators, dental, etc.).
- Provide a draft model and process to outline what will be implemented first.
- Develop a vision statement as it tells a lot about what you are doing.
- Community planning – each community to begin a planning process to get ready for health transformation (NAN and Tribal Councils to support the community process).
  - NAN to advocate for community health planning.
- Define roles and responsibilities of Health Authorities in this process.
- Work together with First Nations, Tribal Councils, NAN and service providers.
- PTO to take the lead and move forward.
- Find a way to address nursing issues in communities immediately (people are falling through the cracks when being assessed by nurses only).
- Each region is different and uses different services and hospitals. We need to develop regional approaches (Northwest, Northeast and Southern).
- Use the reports and dialogues that have already been collected for many years, but especially for the past two years (special needs report, mental health report, all the other reports on issues e.g. NIHB, SLFNHA information and other Tribal Council area information) to engage communities about the work that has been done and the findings of these reports so far, so they understand the scope of issues and can understand health transformation better.

#### **Other Comments**

- Health transformation needs to be evaluated in terms of Treaty and non-derogation of Treaty Rights.
- Chief and Council need to be educated on the importance of using funds for health and training for band managers.

#### **Ovide and Sol spoke to some immediate next steps:**

- A meeting with youth, Elders and women will take place in March. It will be an opportunity to hear from each of the groups and to bring the groups together.
- An engagement approach will be determined in the next couple weeks and the resource allocation to support the process will be determined and communicated at that time.
- A communication plan will be implemented to keep everyone informed.

Elder Alex Moonias spoke to the teaching that there is a lot of medicine in our own backyard and that the land will teach you. When Elders teach they will not teach you in detail – you have to find it and make it bigger and bigger. If you want to develop a model, think about the visions of the Elders and the stories they have and their teachings (use the creation and the 7 teachings). We have to remember that everything is a cycle, the cycle of everything (the sun, the stars, the universe) does not have a box. He also explained that the wind blows to everyone including the trees and the animals. We need to stand together as it is the nature of the trees as they have

stood together for thousands and thousands of years, and the trees have roots, so remember that the model has to include everybody and be circular as it goes on and on forever.

Ovide thanked everyone for sharing knowledge, hopes and expectations and committed to honouring the words as much as we can and to share everything with the delegates and to being transparent:

- Grand Chief Alvin Fiddler has made his personal commitment as this portfolio falls directly under him. He also described the respect from government that our leaders have and that they have gained over the years. This is evident in the Prime Minister Justin Trudeau visiting the territory and the Premiere Kathleen Wynne and Ministers attending the NAN Chiefs Winter Assembly.
- We will ensure that no one is left behind and that we will work with everyone (AFN, COO, etc.) and we will commit to honouring the people and their words.
- We want to you to keep us accountable and keep our feet to the fire.
- We need to think beyond our existing institutions and develop our own laws – to be leaders in law-making and not just going after governments to close the gaps.

APPENDIX A

# Survey Results HST Meeting Jan 29-30, 2018

**1. Understanding that all the items in the following table are priorities, please rank them according to the following:**

- a) Critically important to the success of the health system transformation process
- b) Very Important to the success of health system transformation process
- c) Moderately important to the success of health system transformation process
- d) Not important to the success of health system transformation process

**2. Please indicate which of the following timeframes is most appropriate for reach priority in the table below.**

I Immediate

MT Medium Term

LT Long Term

Thirty-three delegates responded to the survey. It is important to note that a small number of respondents did not rank every single priority, and that a few respondents felt that several priorities were immediate, medium and long term. For this reason, the percentages do not necessarily add up to 100%. However, the chart provides a clear indication of the most critical priorities to be addressed under health system transformation, and which priorities overall were immediate by the respondents.

**\*The list of priorities was developed from delegate input on day one of the meeting.**

Table 1. Percentage of survey respondents who selected each of the categories from questions 1 and 2.

PRIORITY	% a	% b	% ab	% c	% d	% I	% MT	% LT
Legislation and Policy - New and Amended	81	12	93		6	66	12	15
Health service delivery Infrastructure (offices, examining rooms, equipment)	63	21	84	6		56	21	15
Community Infrastructure – housing, water, sewer etc.	81	15	96			78	6	15
Alignment of funding at all Levels	63	30	93	6		48	27	27

<b>PRIORITY</b>	<b>% a</b>	<b>% b</b>	<b>% ab</b>	<b>% c</b>	<b>% d</b>	<b>% l</b>	<b>% MT</b>	<b>% LT</b>
Coordination of community programs and services	51	30	81	12		45	39	15
Coordination of programs and regional services	54	30	84	15		48	30	24
Data collection and management at the community level	51	30	81	9		42	39	15
Data collection and management at the regional	42	48	86	3		45	39	15
Community education and awareness about health system transformation	69	30	99			69	12	15
Protocols and structures for bringing community concerns to the negotiation table and for reporting progress	66	33	99	3		60	18	12
Community Input to the Process	81	18	99	3		85	9	3
Addictions	57	27	84	6		60	21	9
Mental Health	72	21	93	3		60	24	9
Addressing NIHB issues (access, transportation, escorts, pharmacy, dental, vision)	72	27	99			51	21	48
Long-term care facilities	57	13	70	3		42	30	24
Home care	54	36	90	3		30	36	24
Palliative care	42	42	84	6		36	24	30
Respite	54	24	78	15		36	24	30
Diabetes	64	21	85	12		57	9	30
Early Years education and programming	45	30	75	12		39	30	18
Culture and language revitalization	51	30	81	9		39	30	18
Land-based healing	64	24	88		3	60	18	15
Community-based Clinical mentorship	39	27	66	21		27	27	36
Training and capacity building	51	42	93			30	42	21
Accreditation of community workers	45	13	58	12		36	36	10
Standards of care	60	24	84	6		39	18	21
Nutrition and food security	54	24	78	15		45	24	18
Trauma Informed care	45	36	81	9		51	33	15
Public Health Education	48	30	78	12		36	36	18
Early diagnoses and Intervention for disease and mental health issues	69	12	81	3		66	9	12
Suicide prevention, Intervention and treatment Services	88	9	97	3		66	15	9
Recognition of traditional healers and equal compensation for their services	60	21	81	6		48	30	15
Use of traditional medicines	60	21	81	9		39	21	18
Impacts of climate change on physical and mental health	30	39	69	15		18	18	30

<b>PRIORITY</b>	<b>% a</b>	<b>% b</b>	<b>% ab</b>	<b>% c</b>	<b>% d</b>	<b>% l</b>	<b>% MT</b>	<b>% LT</b>
Equitable allocation formulas based on community need	63	18	81	3		63	18	12
Multi-year funding	75	15	90	3		54	12	12
Working together with First Nations, Tribal Councils, PTO (NAN), as well as COO, AFN, Service Providers, Fist Nation regional organizations	72	15	87	3		75	3	15
A NAN First Nations specific health system	54	33	87	13		33	21	36
Study of existing health transformation systems (e.g. BC, Halifax, New Zealand etc.)	45	33	78	6		39	30	12
Remoteness Coefficient	51	33	84	6		42	18	30
More clinicians visiting of a regular basis and/or residing in communities, including nurses, physiotherapists, speech pathologists, occupational therapists, vision care, paediatricians etc.	57	27	84	3		48	15	24
Special needs identification, assessment and treatment	60	24	84	6		48	15	24

**Questions 1 & 2 Other Comments:**

- We need more indigenous, health-based healing practices for trauma/mental health and we need Elders on the faculty of colleges and universities teaching. Our own Oshki Wenjack should be teaching about medicines.
- These are all priorities but currently mental health and culture and land-based healing to address mental health should be number one according to what people are saying at this meeting.
- Protection of Treaty Rights.
- Need to improve hostels and accommodation for people who are travelling for services and treatment.
- An appropriate Suboxone program with aftercare in each community that focuses on helping people come off Suboxone, based on real community data and needs.
- We need to prioritize according to “systems” and “services”. E.g. community services like diabetes and mental health in one category and support systems like data systems and data management in another.
- the community for continuity of care. 5 days is not enough to help.
- Changing the crisis response model e.g. 3-month contracts for workers to remain.

Table 2. Top 11 priorities according to the percent of respondents who indicated that the priorities are “critically” important to the health system transformation process.

<b>PRIORITY</b>	<b>% OF RESPONDENTS WHO INDICATED THAT THE PRIORITY IS CRITICALLY IMPORTANT TO THE HEALTH SYSTEM TRANSFORMATION PROCESS</b>
Suicide prevention, Intervention and treatment Services	88
Legislation and Policy - New and Amended	81
Community Infrastructure – housing, water, sewer etc.	81
Community Input to the Process	81
Multi-year funding	75
Working together with First Nations, Tribal Councils, PTO (NAN), as well as COO, AFN, Service Providers, Fist Nation regional organizations	72
Addressing NIHB issues (access, transportation, escorts, pharmacy, dental, vision	72
Mental Health	72
Community education and awareness about health system transformation	69
Early diagnoses and Intervention for disease and mental health issues	69
Protocols and structures for bringing community concerns to the negotiation table and for reporting progress	66

Table 3. Priority ranking according to the percent of respondents who indicated the priority was “a”, critically important, or “b” very important to the health system transformation process.

(a + b)

<b>PRIORITY</b>	<b>% OF RESPONDENTS WHO INDICATED THE PRIORITY WAS EITHER CRITICALLY IMPORTANT OR VERY IMPORTANT TO THE SUCCESS OF THE HEALTH SYSTEM TRANSFORMATION PROCESS</b>
Community Education and Awareness about Health System Transformation	99

Protocols and structures for bringing community concerns to the negotiation table and for reporting progress	99
Community Input to the Process	99
Addressing NIHB issues (access, transportation, escorts, pharmacy, dental, vision	99
Suicide prevention, Intervention and treatment Services	97
Community Infrastructure – housing, water, sewer etc.	96
Alignment of funding at all Levels	93
Mental Health	93
Training and Capacity Building	93
Home Care	90
Land-based Healing	88
A NAN First Nations specific health system	87
Working together with First Nations, Tribal Councils, PTO (NAN), as well as COO, AFN, Service Providers, Fist Nation regional organizations	87
Data collection and management at the regional	86
Diabetes	85
Health service delivery Infrastructure (offices, examining rooms, equipment)	84
Coordination of programs and regional services	84
Addictions	84
Standards of Care	84
Palliative Care	84
Remoteness Coefficient	84
More clinicians visiting of a regular basis and/or residing in communities, including nurses, physiotherapists, speech pathologists, occupational therapists, vision care, paediatricians etc.	84
Special needs identification, assessment and treatment	84
Data collection and management at the community level	81
Culture and Language Revitalization	81
Use of Traditional Medicines	81
Equitable allocation formulas based on community need	81
Respite	78
Nutrition and Food Security	78
Public Health Education	78

Study of existing health transformation systems (e.g. BC, Halifax, New Zealand etc.)	78
Early Years education and programming	75
Impacts of climate change on physical and mental health	69
Community-based Clinical mentorship	66
Accreditation of community workers	58

Table. 4. Priorities that should be addressed immediately during the health system transformation process,

Over half of the survey respondents agreed that the appropriate time frame for addressing the following 15 priorities during the health system transformation process is “immediately.”

<b>PRIORITIES</b>	<b>% RESPONDENTS</b>
Community Input to the process	85
Community Infrastructure – housing, water, sewer etc.	78
Working together with First Nations, Tribal Councils, PTO (NAN), as well as COO, AFN, Service Providers, First Nation regional organizations	75
Community education and awareness about health system transformation	69
Suicide prevention, Intervention and treatment Services	66
Legislation and Policy - New and Amended	66
Early diagnoses and Intervention for disease and mental health issues	66
Equitable allocation formulas based on community need	63
Addictions	60
Land-base healing	60
Mental Health	60
Protocols and structures for bringing community concerns to the negotiation table and for reporting	60
Diabetes	57
Health service delivery Infrastructure (offices, examining rooms, equipment)	56
Multi-year Funding	54

Addressing NIHB issues (access, transportation, escorts, pharmacy, dental, vision)	51
Trauma Informed Care	51

\* Other priorities were identified as medium or long term or both

(See Table 1)

**3. How would you like to receive information about health system transformation?  
Check all that apply.**

### Table 5. Communication Preferences Results

Communication methods ranked according to percent of respondents that checked each of the following.

COMMUNICATION METHOD	% RESPONDENTS
Regular Updates at Tribal Council Meetings, NAN Meetings etc.	85
A Health Transformation Website	81
NAN and TC Website	70
Visits from the NAN Negotiating team	67
Community Meetings	67
Wawatay Radio	64
Newsletter	64
Community Radio	60
Chief and Council	58
Facebook and Social Media	54
Visit from Government Team	36

**Communication - Other Comments:**

- Small group meetings in the community
- Home visits, especially to Elders or those who cannot get out. Also provide daycare and rides to community meetings
- Face-to-face at meetings that also include other communities
- Develop accessible information materials and translate into our language
- Create a NAN Health Directors update, and include HST
- Provide support to FNs to develop own websites so they can keep community members up to date
- Develop email distribution of lists that include community workers, health directors, education directors, C&C and other sectors to keep everyone up to date. Identify who will do this and how often they will send the updates to all concerned.
- Matawa has established a health cooperative. We would like the funding to educate our communities through the cooperative
- TC directors should be invited to participate in community meetings

- Regular meeting with NAN HAG – TC organized strategic sessions and community meetings
- Emails, meeting updates and reports
- Send updates and information directly to community members – this can be done through un-addressed ad mail as I have seen this done and have received information this way before
- Set up information booths at meetings and events including off-reserve meetings and events

**4. How would you like to give input or feedback to the health system transformation process?**

- Through email and Q & A during TC, NAN and FN meetings
- Through C&C and visits from the NAN negotiating
- Continue to invite the same people who were at the Health Director’s meeting and keep them updated by conducting similar gatherings about health system transformation at least twice a year
- I would like the government to attend some of these meetings, so we can hear directly what their commitment is and give them feedback on their plans for HST
- HST website and email
- Through our NAN HST representatives
- Mechanism whereby I can speak or submit ideas to the process
- Communities need an opportunity to share what is happening in their communities so that we can build on each other’s successes. We need opportunities to share with each other

**5. I am a:**

- First Nation Health Director
- Tribal Council Health Director
- Service Provider
- Other \_\_\_\_\_ (optional to provide title)

**Table 6. Respondent Breakdown**

RESPONDENTS	NUMBER
First Nation Health Director	16
Tribal Council Health Director	3
Service Provider	4
Other	10

• Band Councillor	2
• SLFNHA	3
• TC Rep	1
• Not Specified	4

**6. What do you think the next steps for the health system transformation process should be in your community, Tribal Council or PTO?**

- Community engagement and community education about the process – rapid reporting and updating to the communities on HST
- Negotiation team and engagement to visit communities - create a presentation that the community understands and ensure TC Health Directors are invited to participate
- Community planning – each community to begin a planning process to get ready for health system transformation – NAN, TCs to support the community health planning process
- Define the roles and responsibilities of health authorities in this process
- NAN to advocate for community health planning
- Planning at the TC level and planning support for FNS
- Working together with FNs, TCs, NAN and service providers
- Information sharing and education to Tribal Councils, so they can educate their Chiefs and their Chiefs can educate the community
- Using the reports and dialogues that have already been collected for many years, but especially for the past two years (special needs report, mental health report, all the other reports on issues e.g. NIHB, SLFNHA information and other TC area information engage communities about the work that has been done and the findings of these reports so far, so they understand the scope of issues and can understand HST better.
- PTO must take the lead and move forward
- Hire community engagement workers at TC level and fund adequately to go to communities as often as needed
- Find a way to address the nursing issue in communities immediately – people are falling through cracks being assess by nurses only – need more training and more doctors to visit – we must address the shortages and start training and planning
- Each region is different and uses different services and different hospitals. One region does not appreciate the other region’s issues. We need to group into 3, Northwest, Northeast and Southern

**7. Other Comments**

- Do not change Treaty related health agreements
- Transformation needs to be evaluated in terms of Treaty and non-derogation of Treaty Rights

- Accountability is still a must. C & C need to be educated on the importance of using funds for health and training for band managers so that there is no mismanagement of funds under the new system.
- It is critical to address crisis costs including flights, expenses, funeral costs. Look for options for communities to have appropriate crisis funds or include in health system transformation
- Support community planning with each FN in order to prepare for HST – include planning on coordination of community services and programs
- South, Northeast, Northwest should be 3 health system entities
- Communities need their own dollars to identify community needs
- We need community education on this process, but we need community education on health issues, especially mental health, trauma and addictions
- Involve our youth. They are the future for this new system
- Ensure the process is community-driven and transparent

## APPENDIX B – Detailed Responses of Day 2 Discussions

### GROUP ONE (Tribal Council Health Directors)

- **What does health transformation mean to you?**
  - Transformation is about fundamental Treaty Rights and about control and authority and developing First Nations legislation. This involves moving away from the LHINs and developing our own system.
  - Tribal Councils (roles are changing).
    - Training
    - Strategic planning
    - Supporting
    - E.g. IFNA - prevention / land-based
      - More staff
    - Health Transformation – community workers.
    - Tribal Council role – information sharing between NAN and First Nation.
      - Capacity
      - Innovative contractor
      - Coordinate capital planning
      - Program planning
      - Community assessment
      - Flexibility to carry and move over dollars.
  
- **How do we implement health transformation?**
  - Health Transformation is happening – share best practices!
  - Doing more training and strategic planning at the Tribal Council and the Community Level:
    - Community Coordinators
    - Engagement Coordinator
    - Contact at each community – or how to contact someone to do so.
  - Coordinated Capital Plans
  - Sharing Best Practices
  - Hubs across NAN for hospitals and long-term care until available in other communities.
  - Combine different systems to create unique system at the community level.
  - Study other models (Alaska – Nuka Model, Halifax Model, New Zealand Aboriginee model).
  - Fix the existing services.
    - Things are all over the place and very fragmented
    - Urban areas are also fragmented.
    - No coordination between services.
  - Case management
    - Human resource training.

- Rapid Access Addictions Medicine.
  - Ontario Renal Network.
- Enhance what is working and change what is not working.
- Break down silos.
- Look at standards of care and nursing ratios.
- Support communities more.
- Update funding models.
- Develop new funding mechanisms and ensure funding is needs based including remoteness factor.
- Streamline the reporting system.
- Economic development.
  - Lessons learned (e.g. mining)
  - Creates different classes
- NAN to support Tribal Councils who will then support First Nations re: governance and Treaty and services.
- Political/admin/coordination/communication (more staff needed).
- Best possible health care delivery – hospitals in our communities.
  - Equipment
  - Not just a nursing station
- How can Tribal Councils get a portion of the administrative dollars as a Health Canada (ISC) program?
- Address social determinants of health.
- People need to understand the difference between NIHB and health services.
- Not devolution
  - Enhanced services
  - Better access
  - Capital is a priority
  - Bring all parties (INAC, Province, Health Canada, others) together.
- Look at other processes to understand how they are proceeding (e.g. Education and Child Welfare).

➤ **Community Engagement**

- Recommend a worker in each community – but also acknowledge that there are human resource recruitment challenges and existing difficulty with filling community positions.
- Some Tribal Councils felt they need someone at the Tribal Council to be the liaison - others felt that it is not their mandate and that the relationship should be between NAN and communities, but that it needs to be worked out.
  - Windigo: worker in each community, not at Tribal Council. Tribal Council involvement would be through the NAN Health Advisory Group (HAG).
  - Matawa: Coordinators at the Tribal Council to work with community level and have one coordinator in each community. Need to recognize the different priorities between communities and Tribal Councils.
  - IFNA: Needs direction from Chiefs in order to determine.

- Mushkegowuk: NAN would be the support to the Tribal Councils to move to their inherent right to govern.

➤ **Effective Use of Existing Resources**

- Do not reinvent the wheel.
- So many reports – have been asked the same questions several times. It was recommended that time be spent to research and use existing information.
- Some TC and FN have started transformation and there is a lot to learn from that:
  - Matawa Health Co-op
  - Community transfers
  - To go forward – TC and FN have started the work and they need the resources to continue the work. In some areas they are already going and just need the resources.

**GROUP TWO – NAN Northwest 1 – Community Health Directors (IFNA, Mishkeegogamang, Sandy Lake, Windigo)**

➤ **What does health transformation mean to you?**

- Taking over our health services within our own areas.
- Community awareness through multiple communication methods (visits/media).
- What we used to be.
- Create health care access equally but respect unique needs of each community.
  - “Govt gave us this system – we need to create a new system with our own guidelines.”
- Priority – services available when needed – people’s lives are at risk.
- Revisiting policies and procedures to have more access and choice to services that for our people:
  - Mechanisms for 2<sup>nd</sup> opinion
  - Provide traditional healing options
  - Terminate NIHB (but ensure proper coverage)
- Reduce the bureaucracy.
- Create a voice for people on health care choices/preferences.
- Process to change mindsets to taking more individual ownership of your health, believe you are the expert in your health care, you are a partner in your care, you must be accountable and that you can change the system - Assume control (individual and community ownership of health).
- Governance models for health services.
- Train health managers and admin.
- Scope of practice – nurses and doctors – many nurses are doing the work of doctors (out of their scope) – many bad outcomes from this (guesswork, poor diagnostics) – community expectation that nurses are doctors.
- Change the cause of “bad outcomes.”
  - Bring back northern clinical training program.

- Increase clinical training of nurses.
  - Add other workers (e.g. Lab Technicians).
  - Improve nursing services (look at new models and learn from the work of Tribal Councils [KO and Matawa]).
- New model should separate wellness issues from urgent issues - so many wellness areas (diabetes, babies, etc.) get neglected because nurses are busy with urgent issues.
- How do we translate the term Health Transformation? It does not translate easily, but a few versions had been thought of previously.
- Promote health careers.
- New medical model is required – many health care workers are tied to employers in larger centres that restrict where they can give care and how much out of hospital care they can give – community is at the mercy of that employer.
  - Communities should be allowed to hire their own doctors and specialists or at least have more of a say.
    - Slate Falls has been hiring its own nurses for a long time and have good things to say about it, although they are bound by Health Canada rules (the decision was initiated by a nurse working in the community 11 years ago).
    - Should be able to access any additional funds towards the end of the fiscal year for new hires.
- Continued telemedicine as part of the solution but does have its own issues, including miscommunication/misinterpretation – excellent case management and care inquiry is crucial.
- Need patient navigator or liaison for when community members are discharged; hospital discharge plan is not communicated to the right person (i.e. Someone in the community) or is not relayed at all.
- Many issues with faxing.
- Ethics need to be strongly enforced as control is transferred over to communities (ethical business models) - importance of building strong teams through mutual understanding and respect of care delivery.
- Public and leadership must be well informed as to what exactly we are talking about here.
- Concern about creating another bureaucracy.
- Build strong health teams with mutual understanding “we can do it.”
- NAN Health Act – funding from Treasury Board not from government departments.
- Facilities – capital funding
  - Expansion
  - New space for workers
  - Living space for professionals.

➤ **Community Engagement**

- How to communicate:

- Radio
- Facebook
- Suggestion box in band office or nursing station
- Handouts
- Focus groups (elders and youth)
- Interviews
- Home visits
- Bingo
- Any event around food
- Honorarium
- Sometimes concepts are well received by youth through modern music and art, whether it is receiving it as an audience or creating it themselves.
- Language to be appropriate for that community – both if needed (English, Ojibway, Cree, Oji-Cree).
- No leading questions.
- Not too technical.
- Bring food.
- Language is descriptive – transformation = dramatic change.
- Pre-visit planning – learn about local history, services, etc.
- Kids, video-youth, small packages of information.
- Recognize that change is a process – therefore do not just do one visit and take slow steps.
- Length of community visit
  - Based on size
    - Large community (population of 3,000) – should be 5-7 days
    - Medium (population of 400) – 3-4 days
    - Smaller (population of 200) – 2 days
  - Set targets – e.g. 80% of the community reached.
- Hit community interests – e.g. if a community wants an acute care unit in the community – target and support that and help find the funding.

➤ **Effective Use of Existing Resources**

- Need regional services like Health Authorities but we need more community services.

**GROUP THREE - NAN West 2 – Community Health Directors (Shibogama and Bearskin Lake FN, Emily King (Chiefs of Ontario – NIHB Navigator))**

➤ **What does health transformation mean to you?**

- Moving forward towards a better health system.
  - More access to specialists.
  - Ownership – making our own decisions.
    - Stop having to beg and ask for permission to realign resources.
  - Community consultation

- Based on the Treaty Right to Health
  - Knowledge on how jurisdictions work and a clear outline of jurisdiction/responsibility (then we would not need to even have Jordan's Principle).
  - Federal and provincial acknowledgement of Treaty and Fiduciary responsibility
    - Transparency around how this is done.
  - Recognize NAN's uniqueness that the Treaty was signed with Canada and Ontario.
  - Resources from lands
    - Other Treaty partners have benefitted from the Treaty because the resources have not been shared and inequality exists.
  - Definition of health – for going forward and how it is based on the interpretation of the Treaties.
  - We need to clearly state where we stand and how.
    - Practically, what does it look like? Legislation?
  - Funding
    - Contribution Agreements should be based on what the community wants to do not what Health Canada wants.
    - Increase direct funding and increase flexibility by lifting restrictions (communities know what they need)
      - Choose Life funding is a good example of how it should be done (direct to community, based on community needs and flexible)
    - Address funding caps
  - We have an opportunity here, so we need to do it right and not rush it!
  - Better services at the community level
    - More access
    - More doctors and nurses
  - Less sick people – healthier people, families and communities.
  - NIHB – needs to be changed.
  - Test of Partnership (put money where their mouth is now)
    - Immediately increase access
      - Increase nursing resources
      - Increase physician days
      - Adequate dental and optometry
      - X-Ray equipment

(Access to nursing, physicians, dental and optometry can be done by increasing resources and developing appropriate and competitive compensation models.)

    - Go back to each Contribution Agreement and find shortages – put resources there ASAP

- Allow for community health plans to be updated to reflect reality (currently, transfer communities are stuck in their original health plans)
- Cost savings to be reinvested back into community programming (e.g. savings that arose from the Prescription Monitoring Program)
- Transformation = Ka yan chii sek (changing, currently evolving, it describes the change itself – not static)
- Concerns about off-loading or being locked into something
  - Learn from the experiences of Transferred communities (based on original health plan – they cannot change them without impacting the funding – not updated based on need, changing priorities, increased costs or increased populations).

### ➤ **Community Engagement**

- Go to every single community multiple times
- Enhance existing health plans
- Patient experience (cancer, diabetes, suicide, etc.)
- Expand on items from the Summit
- 2-way communication - people need to know what is going on
- Sioux Lookout area rep on the Chiefs Council (from fly-in community)
- Talk to people and find out what their goals are for themselves and their families.
- Position in each community recommended.
- Methods:
  - Door to door consultation.
  - Live broadcast
  - Facebook and other social media
  - Radio announcements (e.g. 2-3-minute commercial/announcement)
  - NAN website – specific to this process
  - Newsletter (translated)
  - Posters
  - Consistent messaging
  - Phone-line to report issues (currently it is done on Facebook)
- Every community to be evaluated on needs and communities to be clear on how the specific needs are being addressed for their community.
- Bring front-line workers together from different communities (e.g. Mental Health workers, CHRs) – could be done in different combinations with different workers (e.g. all CHRs across NAN, or regionally with combinations of workers, CHRs, Health Directors, etc.)
- Clear communication from political level to operational
  - Bring Chiefs and Health Directors together
  - E.g. NAN resolutions are passed which impact community programs (need ways of getting program manager feedback before resolution is passed and communicating the impact of those resolutions to assist in implementation at program level)

- Ask governments what they do with all the information and how it can be shared to this process
  - Communities' right to their own information – but also ability to use information and make change based on that information.
    - E.g. Drug utilization information – communities receive it, but it is useless if you cannot shape or develop programs around it.
- Build trust across the board.
- Talk to community health providers (nurses and doctors)
- “Nothing is too small or too big” (no issue or idea is too small/big)
- Pre-engagement
  - Relationship building before engagement occurs.
  - Develop a pre-engagement strategy (the key is how we prepare for this)
  - 2-step approach recommended:
    - 1) Update people to get them prepared
    - 2) Engagement  
(it is unfair to ask for feedback before people have a clear picture of what this is about).

➤ **Effective Use of Existing Resources**

- Remove existing barriers on how we use resources.
  - Alternative to Contribution Agreements.
  - Eliminate March 31 spending rules.
  - Eliminate flow through funding (costing too much) > turn the model upside down – communities get the resources and flow to Health Authorities, Tribal Councils and NAN for their functions.
  - Change accountability structures to reflect a nation to nation relationship-eliminate ministerial audit by Health Canada (if there is a discrepancy money gets clawed back – there are other ways of maintaining accountability).
  - Restrictions on reallocating funds (must go through many hoops to change funding lines for basic needs).
    - Examples: add another CHR to a community, buy a dental chair, vehicle limits mean always having to buy used vehicles that do not last that long).
- Economic partnerships with pharmacies (e.g. develop our own) and invest back into the system (e.g. CHR's are currently acting as pharmacy/lab techs – we need our own techs).
- Programs need to understand this process before making changes at community level.
- Different levels working together to maximise resources and support each other (AFN, COO, NAN) – we need to understand how these processes work together at a higher level.
  - NAN to ensure that COO and AFN do not pre-empt the work we are doing.

- Use traditional medicines more.
  - Immediate recognition of traditional healers.
  - Include Elders in mental health (include teachings with mental health wellness).
  - Look at grounding (earth as land-based therapy).
  - Treatment centres for families are too far – need facilities to be closer to communities and be land-based.

#### **GROUP FOUR – NAN EAST – Community Health Directors (Wabun and Mushkegowuk)**

##### **➤ What does health transformation mean to you?**

- Accountable to your people – flipping upside down
  - Acknowledging what we had
  - Funding formula to be addressed – should be based on need and cost (geography) not population.
- Funding formulae – inadequate
- Increase in training:
  - Build our First Nation’s capacity
  - FN driven
  - Education institutions
  - Career development needs to start earlier
- Sharing of resources
- Equitable services
- Traditional Health
- Community Governance
  - Hire our own people so that they know what our needs are...and the program that needs to be delivered is driven by the community
  - Community priorities - Flexibility to decide where to spend the money based on needs

##### **➤ How do we implement health transformation?**

- Engage communities
- Develop models that are suitable to each community
- Develop visual models – suitable to communities (northern needs)
- Infrastructure
- Need to transition to from talking to written format - action plans etc. are documented
- Educate all – children, youth, elders, parents re: transformation
- Networking with all concerned
- Joining where common services are happening.
- May have to look at creating 3 organizations to recognize regional differences:
  - Remote, South, James Bay Area
- Economic spin-offs – we need to benefit and build our institutions
- Costs need to be equitable and comparable

- How will transfer payments work? Nation to Nation?
- Funds to be targeted to program and service demands.

### ➤ **Community Engagement**

- Language is critical
  - Needs to be done by people from the area.
- Validation of peoples' hardships
- We need to talk to the people themselves
- Transparency
- 7 grandfather teachings and incorporate cultural aspect
- Talk to people – visual learners
- Consistency in presentation – same people presenting and being involved in the process...
  - Focus groups: youth, parents, elders
- Methods: You Tube, social media, radio
  - Consider timing – e.g. spring/fall hunting...NHL playoffs etc.
  - Reports have to be timely – so everyone is
  - Draft documents to share...so they get an idea of what it will be...
  - Provide the vision statement of HT.
  - Make sure from the area – so limited training in gaining knowledge of the area.
  - Bring a youth worker, so youth is involved.
- Be aware of history of colonization and how it effects our health
- Timely reporting
- Visuals
- Presenters from region
- When engaging youth – bring youth workers along.
- History of colonization as it impacts health
- Proper supports
- Prepare Community Members
  - Increase awareness
  - Hold information sessions to explain what potentially can happen
  - That information is pre-designed before – ppl need to be well prepared and it needs to be done at the community level.
    - One on one conversations.
  - Release the document – have it translated.
  - Ongoing updates
  - Show examples of health care models
  - Hand out pamphlets, door to door, handouts, etc.
  - Mindful of different schedules, who is available when – target appropriate timeframes (working schedules, hunting/cultural weeks, etc.)
  - Needs assessments, gaps and build from there
  - Incremental planning
    - Health Transformation is a big beast

- Make changes as needed program by program – not overnight

➤ **Effective Use of Existing Resources**

- What resources? – We have none and First Nations do not have control.
  - Educate the govt and whoever needs to know of our community-based needs.
- Take stock of resources at community, regional, provincial and federal level.
- Take inventory of programs/organizations
- Look at First Nation, regional, provincial, national and other resources (e.g. Aboriginal nursing organizations, Aboriginal physician association)
- Know what the government funding priorities are and keep updated.
- Authentic relationships
- Ongoing training and education
- Circle of care
- Identify ineffective resources
- Who decides on resources and who prioritizes?
- Network sharing (i.e. Proposals, information, what works and what does not.
- Accreditation and standards
- Risk management
  - organization level and umbrella broader level
- Maximise resources
- Strategic Planning
- Develop own legislation

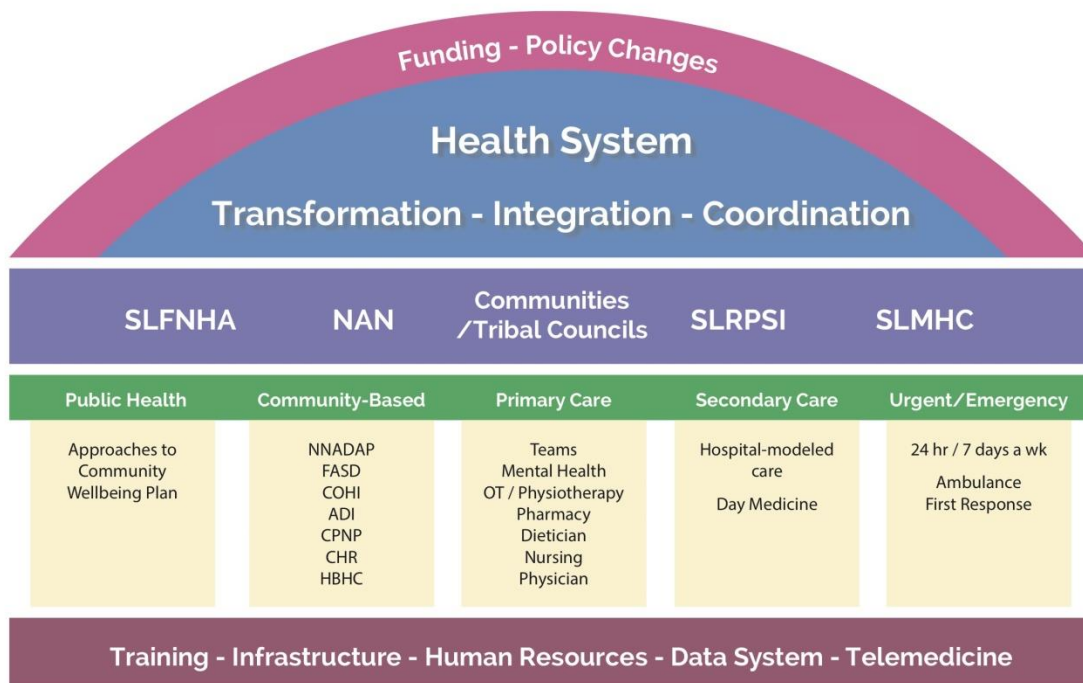
**GROUP FIVE**

➤ **What does health transformation mean to you?**

- Building programs and services that meet community needs and not funder needs.
- First Nations managed and governed health system
- Make sure work that is needed is supported
  - Funding
  - Capacity building
  - Specialized support (expertise)
- Finding a solution for funding and supporting implementation
- Flexible funding model to accommodate needs as they arrive.
- Long term funding not just year to year (sustainability)
- Growth to reflect community needs
  - Cost of living adjustments
  - Pension contributions
  - Support of collective bargaining process
  - Wage parity to reflect Northern reality (Northern Adjustment)
- Understanding roles and responsibilities, working relationships and linkages.
  - NAN
  - Tribal Councils

- Communities
  - Government
  - Health Authorities
- Establishing mentorship for youth
  - Job shadowing
  - Summer placement
  - Support health system (succession planning)
    - Governance
    - Clinical
    - Allied health
    - Policy
    - Administrators
    - Share success stories
    - Case management
- Cross-sectoral linkages (education system)
- A more direct approach to doing things differently
- Building models that work
- Capacity at community level
  - Supporting local needs
  - Have funding support
- Strengthening relationships b/n FNs, HA, hospitals, NOSM, etc.
- Communities need to have a funding relationship with the funders
- Funding flow needs to be timely
  - Automatically happen
- System navigation to help communities understand and how to navigate
  - Communications at all levels
  - Client coordination supports
- Measurement and accountability
  - Data collection/management/analysis
  - Knowledge exchange
  - Community EMRs (systems need to talk to each other)
- System reflects needs/knowledge/traditions
  - System choices
- Social Determinants of Health (water, housing, food, education, income, child protection, social services, elder care)
- Circle of care needs to go beyond what we think the health care system is traditionally.
- Recognition of traditional medicine and healing practices
  - Respecting choice
  - Integration into the system instead of separate from
- Retention of physicians and NPs
  - Compensation structures need to be re-evaluated
  - Benefits

- Health workforce planning advisory table (NOSM, Western U of T, ADMs)
- Relationship with LHIN to be evaluated.
- Infrastructure at the community level
  - Internet band-width for the whole community
  - Services in the home (using technology that is available\_
  - Creating reliable systems
- Knowledge sharing and exchange among communities
- Training and Human Resources Strategies
  - Looking at what the system looks like at local level (building a base)
    - Community Health Workers (CHW) to take on expanded roles – based on learnings from other areas (New Mexico re: CHRs, Alaska re: Community Health Aides)
    - Recruitment & Retention solutions: training and staff development and compensation that would be competitive reflecting high cost of living.
- Reporting and accountability
  - Streamlined reporting > one report
  - Less complicated and easier complete
  - Funder flexibility based on community need
    - Community lead
    - Annual health report
    - Reporting to our own governance system
- Continuous and on-going reviews of our system – amend and adjust as needed.
- Funder reviews and reporting
  - based on needs of communities and community information.
  - Will allow opportunities to identify gaps
  - Implement the changes as needed
  - Community responsive (Hep C, TB, Mental Health / Suicide, Addictions, etc.)
  - Epidemiologist for report development and analysis.
- SFLNHA – Transformation/Integration/Coordination Model
  - Could be built on
  - Talks about funding and policy changes that need to happen
  - What would support that as a foundation as training, HR, data, telemedicine
    - Might mean we include all the other areas into the model



➤ **How do we Implementation Health Transformation?**

- Support existing systems in Tribal Councils and Health Authorities
  - Support structure for implementation
    - Primary care
    - Clinical services
    - Human resources
    - Public health
    - Home and community care
    - Standards
- NOSM
  - Keeping people in the North
  - Starting our own school
  - Selection/grants
  - Is not working the way it is currently
  - Remote and isolated need to be better incorporated.
- Part of process to longer term funding to enhance or expand to whole area.
- Implement something like LHINs –
  - Need a NAN regional Health Network
  - Health Government for NAN territory– somebody who can oversee governance and management issues wrt regional system
    - E.g. data management system
  - Creation of our own legislation (around primary care, public health, insurance (liability) reviews)

- Community Implementation of Mustimuhw
  - EMRs
  - Continue to support implementation
- Supporting communities:
  - Workload for many is not sustainable
  - Develop strong roles and responsibilities
  - Establish a more supportive structure
    - Education and training
    - HR management
    - Administrative duties
- Traditional practices of medicine and healing as part of the system.
- Knowledge sharing system
  - What exists currently
  - Learning from each other
  - Building off this
  - Community of practice.

➤ **Engagement and Communication**

- Utilize existing community-based engagement information
  - Recognize previous processes and build off them (other NAN reports, Anishinabe Health Plan, WAHA Public Health Engagement, TRC, JP, coroners reports, etc.)
  - Have communities reflect on it
  - Reconfirm information and add to if needed.
- Engagement with various providers and partners
  - Health
  - Chief and councils
  - Education
  - Social
  - Police
  - Emergency services
  - Infrastructure (housing, water)
- Targeted strategies (youth, Elders, children, women, etc.)
- Methods: Facebook, social media, face to face, radio, drawing, graphic recording, feasts, prizes.
- Customized questions to reflect communities
- While doing engagement you want to build capacity – this requires ongoing support to communities
  - Use community experts and resources
- Engagement needs to be done in a timely fashion – so adequate resources and teams and language is an important part of it.
  - Staff
  - Communities
  - Consultants

- Adequate resources and supports
- Language (translation in all dialects)
- Timely feedback
- Validation of findings to ensure we capture community needs.
- Managing expectations of communities (if government changes we need to be able to deliver through immediate resources on the ground)
  - Reinforce government commitment > how do we do this? With the Charter?
- Consistent messaging going out to all parties.
- Not just one-time engagement – needs to be ongoing (feedback loop coming in and going out)
- Engagement leads to planning and implementation (sustainability) – does not just go away.
- Put supports in our communities immediately
  - Navigation supports
  - Advocacy supports
  - Need someone who is objective to talk to at the local level where there are needs not being met
    - Issues with services provided through nursing system
  - NIHB
  - Authority to be able to questions the system
- Support for local health committees that are in place (quality and accountability)
- Support for council member with the health portfolio
- Support for elected officials (funding, succession planning, training)
- Training funding needed at all levels of the system
  - Professional development
- Program delivery
- Communities/Tribal Councils / Health Authorities / PTOs
  - Knowledge sharing among each other
    - Successes
    - Failures
    - Learning
    - Implementation
    - Guidelines
    - Policies/procedures
  - What support do communities need:
    - Recruitment and retention
    - Compensation (harmonization) to minimize competition amongst each other.
      - Also incorporate outside competition
      - Everything has to be competitive
  - Impacts on services and programs (workspace, housing, program space, infrastructure (retention), economic spin-offs.

- How we treat people when they come into our communities to work
  - How do we resolve conflict (BCRs etc.)?
- Child care / education upgrades.
- Respect for compensation and benefit structures (pension, dental, medical, holiday, work-life-family balance)

➤ **Effective use of existing resources**

- Identify existing resources and potentially new resources with health transformation process.
- Sharing information and working together
- Establishing a work plan “Road map” – big picture
- Customise reports per community
- Data management (funding beyond 3 years)
  - WAHA/SLFNHA partnership
  - 2 Epidemiologists
  - Mamow Ayhamowen (HSIF/HC)
  - Build sustainable budget for the future.
- Public Health, Jordan’s Principle, Data management > we need long term commitments to establish systems.
- Re-alignment of funding (Family Wellbeing Workers – fits with public health)
- Better integration so that positions are supported
- Community mapping of what exists right now
- Build on KO Telehealth network
- Infrastructure supports
  - Bandwidth
  - Private space for consultation with patients
  - PCVC
  - Technology upgrades (simple, user-friendly – not intimidating – ensuring privacy)
- Look at existing resources to analyze most effective way to use the model/resource – e.g. existing epidemiologists
- Support regional planning processes and integration into the system.
  - What is in place right now?
  - Is there a need? Can it be filled or met in the existing system?
  - Make a decision based on information that is available – talk to each other.

**GROUP SIX**

➤ **What does Health Transformation mean to you?**

- Change
- To enhance and improve services to the health programs (because they are broad)
- Have funding go directly to communities
- Have something built that meets communities’ needs

- Grassroots
- Have a say in how guidelines are developed – have a say in how to spend money and be flexible.
- Develop policy that will work for us.
- Community-based, community driven
- Having more centres, based on cultural traditional teachings.
- Reducing the bureaucracy
- Filling the gaps.
- Getting rid of formulae which do not reflect needs
- Better pharmacy system (Indigenous run and owned)
- Better research on plants and herbs and to pass on the knowledge
- More recognition for traditional medicine/doctors
- Take back spiritual needs
- Better change for community needs
- Building a foundation
- Better housing
- Better water
- Midwifery
- Infrastructure – capital within the Health Transformation framework
- An experienced consultant to liaise between
- Community wellness (e.g. community gardens)
- Use existing models to save time and to save money
- Has to be sustainable
- Suspicious of long term motives within government
- Education on transformation
  - Training for health care providers and getting youth to go with health care professionals.

➤ **How do we Implement Health Transformation?**

- Just do it!
- May take years
- Has to be through education system and part of the curriculum
- Revive the language
- More information sessions
- Educate people about the issues
- Community engagement – have a committee to visit each community
- Having programs in colleges/universities
- Need a new Health Transformation Minister
- Having a relationship and partnership and understanding from government to government.
- We need to hear a long-term commitment from government –
  - What will be the roles and responsibilities?
- Partnership with training institutions (i.e. Oshki) for other health careers.
- Better living and services for elders to avoid elder abuse

- Where is the accountability?
- Need to see progress and follow-ups after meeting is done.
- Need to see a timeline of goals.
- Have more funds available and to flow better between programs
  - Funeral costs
  - Miscellaneous costs
  - Educate people that government will not help with some costs.
- Leadership needs to be involved.
- Community members need to be involved
- All ministries need to be involved
- Need more nutrition programs and nutritious food (food security) and control over food systems
- Parents need to be involved
- Change education curriculum to make change
- Hospitals need to be involved (advocacy, translators, navigators)
- Better network of navigators
- Ombudsman/spokesperson to speak for patients
- Transportation
- Drug benefits
- Youth internships/job shadow
- Funding / budgets for programs is different for each community
  - Each community has unique needs
  - Set amount should be given – should not just be based on community size
- Need to groom youth to learn about health careers – give them incentives.
- Use Oshki (or other training)
- Promote health curriculum
- Involve youth in decision making
  - They see things that we do not
  - Look beyond “tunnel vision” of how community might see youth.
  - Youth need to be heard not just seen.
- Leave info at nursing station
- PSA on TVs at waiting rooms, on community channels
- Look towards future and change mentality from past experiences – i.e. 60s scoop.
- Develop a slogan (something to make people remember)
- More cultural activities – land-based.

➤ **How do we prepare our community members for Health Transformation?**

- Through Wawatay News with translation
- Through APTN
- Door to door campaign
- Billboards
- Social Media

- Circles, working sessions, gatherings, feasts
- Info packages – translated
- Awareness of changes
- Syllabic translations
- Communication
- Recordings
- Televised meetings
- Writings
- Workshops
- Enhanced wages
- Feedback from workers and community members
- Make leaders understand Health Transformation
- More opportunities

➤ **How do you see engagement happening in your communities?**

- Facebook – social media
- Youth being involved
- Group meeting with different levels
- Consistent follow-up in terms of community visits – having a questionnaire door to door
- Surveys
- Documentaries
- Rallies and walks to raise awareness
- Access to NAN website on Transformation
  - Surveys accessed through website
- Committees of groups (i.e., youth, parents, educators, nursing staff, elders)
- Newsletters
- Emails
- Committee meetings
- Conferences
- telehealth
- Radio station
- Health related career fairs
- Pamphlets and posters
- Radio talk shows
- Home visits
- Art therapy
- Music
- Interviews – video and transcribe
- Matawa Health Co-op
- Translators at NAN office
- Develop data system

- Matawa – communications, policy analyst, coordinator, project leader, workers (9 communities, office space in the First Nations).
- **How do we effectively use existing resources?**
  - Revise and update the resources to meet communities needs
  - Reduce overlap and duplication of resources
  - Update webpages
  - Open communication between off and on reserve programs and services
  - Better reporting system and formats
  - Reduce turnover of staff at health centre
  - Need more information on hand on how health care works
  - Leadership needs to be involved
  - Fix pharmacy issues – (double prescribing, consultation, etc.)
  - Bring back herbal medicine
  - Improve Canada Food Guide